

Mapping The Offender Health Pathway: Challenges and Opportunities for Support
Through Community Nursing

Cyril Eshareturi MPH

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Abstract

The current context of offender health in England and Wales indicates that offenders re-enter their communities with limited pre-release preparation for the continuity of access to healthcare and an increased risk of release with a health condition and very little support to cope in the community. This study was aimed at mapping the ex-offender health pathway towards identifying 'touch points' in the community for the delivery of a nurse led intervention.

The study was a qualitative case study underpinned by 'The Silences Framework' which enabled it to gain theoretically by situating power with offenders, thus, aiding their 'Silences' to be heard, explored and brought to light. Participants meeting the study inclusion criteria were quantitatively ranked on the basis of poor health with those scoring the lowest and confirming their ranking through a confirmation of a health condition selected as cases and interviewed over the course of six months. These interview narratives were confirmed by interviewing individuals in the professional networks of offenders.

The study identified the site of post-release supervision as the 'touch point' where a nurse led intervention could be delivered. With regards to the delivery of the health intervention, the study indicated that the nurse led intervention be provided as an advisory and signposting service structured on a drop-in and appointment basis. Furthermore, the study indicated that pre-release, offenders were not prepared in prison for the continuity in access to healthcare in the community on release. On-release, offenders' on-release preparation did not enquire as a matter of procedure on whether offenders were registered with a GP or had the agency to register self with a GP practice in the community. Post release, the study uncovered a disparity between services which address the physical health needs of offenders and those which address their mental and substance misuse health needs.

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Glossary of terms

The following abbreviations were used in this thesis:

CARAT: Counselling, Assessment, Referral, Advice and Through-care

CJS: Criminal Justice System

CPS: Crown Prosecution Service

CRC: Community Rehabilitation Company

DH: Department of Health

HDC: Home Detention Curfew

HMIP: Her Majesty's Inspectorate of prisons

HMPS: Her Majesty's Prison Service

MAPPA: Multi-Agency Public Protection Arrangement

MOJ: Ministry of Justice

NHS: National Health Service

NOMS: National Offender Management Service

NPS: National Probation Service

STAR worker: Support - Transform – Achieve - Result worker

TSF: The Silences Framework

WHO: World Health Organization

The following terms were used in this thesis:

Axis 1 diagnosis: All psychological diagnostic categories except mental retardation and personality disorder.

Cases: The eight study participants who were identified to be in poor health and followed up prospectively over the course of six months.

Collective dialogue: Semi structured interviews conducted with individuals in the social network of ex-offenders and/or individuals whose professional situation impacts on the lived experience of ex-offenders.

Health: A state of physical and mental well-being which is evidenced by the absence of an illness, disease or infirmity.

Offender Manager/Probation Officer: This is someone from the probation service. They are based in the community and will usually work with offenders under supervision in the community. They may also work with offenders in prison towards preparing the offender for supervision in the community.

Offender Supervisor: This is someone either from the probation service or the prison service seconded to work in prisons. Their role is to ensure that the offender keeps to their sentence plan in prison.

Silence dialogue: Semi structured interview conducted with cases at six months

Touch point: These are points in the community where ex-offenders access interventions to address their various health and structural needs. For instance, job centre, local council office, probation premises, and Accident and Emergency Units.

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1. CHAPTER ONE - INTRODUCTION

1.1 Study introduction

In England and Wales, if you are 'locked up' the National Health Service Commissioning Board is responsible for your healthcare; if you are not, but still in contact with the Criminal Justice System, then individual clinical commissioning groups become responsible (NHS Commissioning Board, 2013). Yet, available evidence indicates that on release, offenders are hard to reach; use health services in a crisis led way and are socially excluded (Williamson 2006; Marlow 2008; Sainsbury Centre, 2008; Rennie, Senior and Shaw, 2009; Norman 2010; Peate 2011; Byng *et al.* 2012). This indicates that whilst healthcare in prison is constitutionally mandated, little effort is made to connect released offenders with community health services as a health excluded group in need of tailored support (Eshareturi *et al.* 2014). This issue is of concern as offenders are at an increased risk of release with a health condition and very little support to cope in the community (WHO 2007; Van den Bergh *et al.* 2011). These high rates of serious health conditions and vulnerability on release generate a situation in need of attention. In response to this, the aim of this study was to map the released offender health pathway towards identifying 'touch points' in the community where nurse led interventions could be delivered.

It is important that a position be declared on how this study constructs ex-offenders towards ensuring that the debate around the meaning of the term does not unwittingly affect how potential readers construct its use within the study. The term 'offender' as used in this study relates to individuals in contact with the criminal justice system due to an offence committed for which they have been imprisoned as

a result. This term is not precise as it is also used to refer to individuals who have committed an offence but may not have received a custodial sentence. However, it is important to note that not all convicted individuals become imprisoned. Nevertheless, most offenders irrespective of imprisonment status share similar characteristics such as drug abuse and poor physical health and engage with the same statutory services in addressing their needs (Brooker *et al.* 2008). Moreover, it is recognised that released offenders may not necessarily be ex-offenders. It is possible for an imprisoned individual to be released to serve a sentence in the community. Although such an individual may have been released albeit under license, technically they are not considered to be ex-offenders as they are still under the supervision of the criminal justice system. However, the terms 'ex-offenders' and 'released offenders' are used interchangeably in this study to refer to previously imprisoned individuals who have now been released into the community irrespective of license conditions. This is also in keeping with the terminology used by academics across the world in referring to this group of individuals (Pogorzelski *et al.* 2005; Williamson, 2006; Marlow, 2008; Salke and Fleming, 2012).

1.2 Study background

Offenders often engage in high risk activities which have negative repercussions to health. These activities include unsafe sexual practice, smoking, drug use and alcohol misuse (Jarrett, Adeyemi and Huggins, 2006). Their health status has been compared to those of the general population and has consistently shown that they present with poor health across a range of conditions which is significantly higher than the rates observed in the general population (Butler *et al.* 2004; Williamson 2006; Bradley, 2009). Evidence specific to England and Wales indicates that most

offenders experience at least one chronic health condition, many with multiple health problems (Byng *et al.* 2012). Correspondingly, the study by Bridgwood and Malbon (1995) indicates that almost half of all imprisoned individuals have some type of disability or chronic illness. Similarly, this was also the case in female and young prisoners (Plugge, Douglas and Fitzpatrick, 2006). In addition, a significant proportion of the prison population in England and Wales has an alcohol or drug misuse problem (Singleton *et al.* 1998).

Following release from prison in the UK, death from drug abuse is also a major concern. Heroin has been implicated in a significant proportion of these deaths in the two weeks following release from prison, often due to a reduction in the ability to tolerate opioids (Bird and Hutchinson, 2003; Farrell and Marsden, 2005). In addition, the prevalence of hepatitis B and C, human immunodeficiency virus and other sexually transmitted infections are much higher than those found in the general population (Weild *et al.* 1998 and Long *et al.* 2001). Other health studies of offenders here in the UK and abroad have shown that mental illness, cardiovascular conditions, asthma and epilepsy are frequently reported (Lader, Singleton and Meltzer, 2001; World Health Organisation, 2003; Anderson, 2011). Similarly, a national study on the health needs of newly sentenced offenders indicates that over a quarter of them (27%) reported having at least one long-standing physical health problem or disability (Stewart, 2008).

Imprisonment leads to traumatic consequences for prisoners and their families (Haney, 2006). In restitution for crimes committed, imprisonment constitutes systematic deprivations tailored towards punishing and psychologically intimidating offenders (Arditti and Parkman, 2011). Although various forms of imprisonment have evolved over time such as open, closed and dispersal prisons, ultimately, these

deprivations may lead to a sense of resentment which may mitigate against rehabilitation and successful re-integration (Arditti and Parkman, 2011; Durcan, 2008). Although being imprisoned could exacerbate psychological trauma, the prison population is overrepresented with individuals from disadvantaged backgrounds who do not have the requisite skills to effectively navigate and optimally use health services in the community (Durcan, 2008). In this context, offenders are likely to be from the poorest social economic group (Brooker and Sirdifield, 2007) and are likely to be poorly educated (Cooke, 2004; Travis, 2005). The World Health Organisation acknowledges the link between inequality and imprisonment, maintaining that the bulk of those serving prison sentences are people from the poorest and most marginalized sections of the population (World Health Organisation, 2003). These suggest that the bulk of the prison population is comprised of individuals with poor health which is exacerbated by being from marginalised sections of the population.

Accordingly, involvement with the criminal justice system could be triggered by social exclusion. Social exclusion aptly describes the situation in which individuals suffer from a blend of connected problems such as unemployment, poor housing, low wages, family collapse, high crime environments and adverse health (Bak, 2012). In the UK, a significant proportion of this population are comprised of released offenders (Williamson, 2006). Fifty percent of these individuals on release will have access to no General Practitioner, 42% have no fixed abode and 50% will reoffend within two years of release (Williamson, 2006). Sixty four percent of prisoners made a benefit claim in the 12 months before imprisonment (Ministry of Justice, 2010a) and only 36% of released offenders go into training, employment or education, leaving these individuals consistently in need of support post release (Bath and Edgar, 2010).

The aforementioned contributes to the lack of knowledge expressed by these individuals of primary health services and influences their use of health and social care services in a crisis led way (Awofeso, 2005; Department of Health, 2007). The Department of Health (2008) indicates that between 2006 and 2007, 36% of the general population attended Accident and Emergency Services (A&E) with the offender population slightly higher than those of the general population at 39%. Although taken at face value these figures do not necessarily indicate that offenders are significantly higher users of emergency medical services, the evidence available indicates that there are key differences between the two groups. First, regular users of A&E in the general population tend to be young children and the elderly. Also, the figure attributed to the general population might well be inclusive of multiple attenders (Brooker *et al.* 2008). When the above figures are taken in the context of the aforementioned issues, it becomes increasingly safe to posit that compared to the general population, released offenders are indeed significant users of emergency medical services.

These individuals are not a new group in need of support; on the contrary, they are a group which is visible in practice but lack recognition in policy (Pager, 2006; Brooker *et al.* 2008). In addition, they also experience structural needs and find it difficult to concurrently address these and those of their health (Social Exclusion Unit, 2002; Department of Health, 2007). Internationally, an American study of 3,073 newly released prisoners with Axis 1 diagnoses, found that newly released offenders faced multiple restrictions and limited access in regards to employment, public assistance and housing; critical resources if the formerly imprisoned individual is to avoid reoffending and begin the process of reintegration (Pogorzelski *et al.* 2005). Here in the UK, similar studies mirror this finding and indicate that released offenders

consider structural needs as more important than health needs (Sainsbury Centre, 2008; Byng *et al.* 2012).

Moreover, the provision of post release programming for released offenders in the UK is not a statutory responsibility. The UK Government's green paper, *Breaking the Cycle* (Ministry of Justice, 2010b), recognises that a considerable proportion of crime is committed by offenders who have multiple problems and maintains that the potential exists for effective rehabilitation to break the cycle of re-offending. In the spirit of this paper, some transitional models are presently being used in the UK to facilitate the continuity in access to healthcare of individuals being released from prison into the community. An example of this is the Integrated Offender Management framework which provides a strategic framework for bringing together relevant stakeholders towards addressing locally determined offending priorities through targeted interventions (Revolving Door Agency, 2012).

However, a limitation of this framework is that it was conceived to exclusively target prolific offenders and is not oriented towards addressing the needs of non-prolific ex-offenders not in contact with the criminal justice system. More recently, the Government in England and Wales has sought to tackle the issue of re-offending by making payment incentives for market providers which it is hoped would incentivise private providers to work with offenders towards providing various interventions aimed at resettling offenders and reducing reoffending (MOJ, 2013b). This proposal is not without its controversy, but it remains to be seen what difference this course of action would have on present practice.

1.3 Study justification

The evidence on the relationship between health and re-offending (Dowden and Brown, 2002; Hobbs *et al.* 2003; Wallace and Papachristos, 2012; Abracen *et al.* 2013) suggests that offenders in poor health can be particularly at risk of reoffending (Social Exclusion Unit, 2002; Social Exclusion Unit, 2004). A qualitative study which interviewed 29 recently released inmates on their community based health experiences indicates that the high level of psychological distress experienced by these individuals makes it unlikely that they would be able to adhere to parole conditions (Binswanger *et al.* 2011). This study indicated that on release, health challenges led former inmates to behaviours that put them at risk of reoffending and inevitably ending up in prison. Worryingly, the post-release experience was considered difficult compared to the prison experience which some participants considered to be safe.

Research on the health effects of imprisonment indicates that prisons may be a place of improved health and correspondingly lower mortality for the imprisoned individual. Studies indicate that imprisoned individuals tend to have lower mortality compared to those on the outside who have been matched on similar demographic indicators such as sex, education, age and race (Patterson, 2010; Wildeman, 2012). However, on release, the protective effect of imprisonment appears to be lost as these individuals become at significantly greater risk of mortality compared to their community based matched controls especially in the immediate weeks following release (Binswanger *et al.* 2007; Rosen *et al.* 2008; Spaulding *et al.* 2011). While it is acknowledged that release from prison should serve as an ideal opportunity for targeted health and social care interventions to achieve socially desirable outcomes by reducing community disruption and deterioration and achieving public health

goals, the evidence to inform such targeted interventions is almost non-existent in the UK (Solomon and Rutherford, 2007). The evidence available indicates that released offenders are hard to reach and get lost between care systems (Social Exclusion Unit, 2004; Awofeso, 2005; Williamson, 2006; Department of Health, 2007; Lim *et al.* 2012).

Upon release, these individuals are unable to access mainstream health and social care services, consequently using these services in a crisis led way (Awofeso, 2005; Department of Health, 2007). This is exacerbated by the fact that most released offenders are not registered with a general practitioner which mitigates against the ethos of continuity of care on release (Norman and Parrish, 2002; Marlow, 2008; Rennie, Senior and Shaw, 2009; Norman, 2010). A study on mental health needs of young offenders both in the community and in custody revealed that significant levels of uncovered needs amongst released offenders were often neglected with suicidality amongst these individuals greatly exceeding those of the imprisoned population (Chitsabesan *et al.* 2006). This was further corroborated by a health needs assessment of offenders on probation caseloads in Nottinghamshire and Derbyshire in the UK. This assessment indicated that although released offenders had significant health needs on re-entry, they correspondingly had significantly less opportunity to access needed service on release into the community compared to the general population (Brooker *et al.* 2008).

Although health problems may be addressed when an individual is in prison, once released into the community these health problems often receive little attention (Solomon *et al.* 2005; Shinkfield and Graffam 2009). Due to their poor uptake of care, a large number of released offenders are at increased risk for exacerbation of illness and transmission of infectious disease to those around them (Marlow, 2008).

Several studies have established a link between poor access to healthcare on release from prison and death in the community (Coffey *et al.* 2004; Hobbs *et al.* 2006; Kariminia *et al.* 2007). A study on the deaths of offenders under community supervision and in prison indicated that on release, male ex-offenders were four times more likely to die than the general male population. This rate was uncovered to be twice as high as that of male imprisoned offenders, with over two fifths of these deaths occurring within 12 weeks of release (Sattar, 2001).

Moreover, while healthcare in prison is constitutionally mandated, little effort is made to connect released offenders with community health services (Freudenberg, 2001) and we know that demand for health services in the community by these individuals is less than the general population (Jarrett, Adeyemi and Huggins, 2006). Although the principle of 'equivalence' was introduced into offender healthcare in England and Wales over a decade ago (Department of Health, 2001), there is no doubt that the lack of health services targeted at released offenders in the community not in contact with the criminal justice system contradicts this ethos. The implication thus is that without targeted interventions, the plight of these individuals could evolve into considerable public health burdens for our communities.

1.4 Implications for nursing

Whilst, the health of released offenders is on average worse than that of the wider public, we know that demand for health services in the community by these individuals is less than the general population (Jarrett, Adeyemi and Huggins, 2006). The care for offender's continuity of access study indicated that despite the evident serious health problems of imprisoned individuals, once released into the

community, these individuals do not prioritise health as being important. This study indicated that competing demands such as housing and employment often interfered with their ability to actively seek help for health needs (Byng *et al.* 2012). In addition, the reluctance of this group to trust health agencies and the stigma they associate with accessing health services to a large extent further contributes to their poor uptake of health services post-release (Wildeman, 2012). Indeed, it is evident that released offenders re-entering their community bring with them significant health problems and a limited understanding of how they can access health and social care services. This lack of understanding post-release is fuelled by the lack of statutory measures in the UK aimed at facilitating the continuity of access to healthcare for offenders as a unique group in need of tailored support post release (Williamson, 2006; Byng *et al.* 2012, Byng, Quinn and Sheaff, 2014). Therefore, this study focuses on exploring and understanding what works with regards to linking released offenders to health and social care services delivered in the community and whether such care could play a role in increasing released offenders' opportunities for successful reintegration.

Undeniably, one of the saddest commentaries on our society is that for many, imprisonment represents improved access to healthcare. In England, available evidence indicates that male and female imprisoned offenders consult doctors three times more than a demographically comparable community population and consult healthcare workers (the nearest community equivalent to nurses) 77 times more frequently for men and 197 times more frequently for women compared to their demographically comparable counterparts in the community (Marshall, Simpson and Stevens, 2001). On release from prison, provision of a high standard of health and social care services to released offenders is imperative. For these individuals,

release should lead to the opportunity to access targeted health and social care interventions which are focused on improving their health. However, uptake of community delivered interventions is more likely to be achieved if these interventions are commissioned to address both their health and structural needs (Brooker *et al.* 2008; Byng *et al.* 2012). Therefore, the lesson herein is that health and social care interventions could be delivered to ex-offenders now living in the community in settings they visit for other services.

Accordingly, nursing is distinctively placed to intervene in the community towards addressing the socially significant health issues which plague released offenders not in contact with the criminal justice system. A study on the provision of a nurse led addiction service in three probation hostels in England indicated that the provision of a nurse to orchestrate care for supervisees led to a reduction in heroin use within the hostel (Payne, 2001). Key elements of this study included prioritising the treatment of drug problems within the hostel and combining an increased utilisation of coercion with a strong onus on abstinence from all drugs. Whilst this study was limited by the fact that a control group was not included, the study nonetheless indicated that the nurse led service contributed to significant improvement in the health of supervisees as the intervention led to an associated reduction in the use of heroin within the premises.

Internationally, the use of a nurse led intervention in facilitating the continuity in access to healthcare for offenders on release from prison has also been demonstrated. A randomised control trial on nursing case management towards hepatitis A and B vaccine completion among 600 recently released offenders in the United States indicated that nursing intervention improved vaccine completion in the community (Nyamathi *et al.* 2015). This study compared after 12 months of follow-

up, the efficacy of three levels of peer coaching and nurse-led interventions: (a) intensive peer coaching and nurse case management, (b) intensive peer coaching with minimal nurse involvement; and (c) usual care intervention which included minimal peer coaching and nurse involvement. Logistic regression was used to assess predictors of completion of the hepatitis A and B vaccine series and chi-square analysis was used to compare completion rates across the three levels of intervention. Although this study was limited by the fact that it did not explore nursing case management as a standalone variable, the results of the study nonetheless indicated that the nurse led intervention was significantly associated with vaccine completion.

Similarly, a study investigating the transitional healthcare for offenders being released from United States prisons with AIDS, tuberculosis, hepatitis, mental illness, and substance abuse indicated that the majority of transitional healthcare planning was coordinated by registered nurses and that this planning enhanced post-release continuity of care by increasing access, decreasing acute-care episodes, controlling the spread of communicable diseases and reducing the financial impact on health systems (Flanagan, 2004). This study collected data using a mail survey which was completed by 33 chief medical officers of prison systems in the United States. Whilst the study was limited by the fact that it was predisposed to data errors due to question non-responses, the findings of the study nonetheless suggest that as discharge planning is predominantly conducted by nurses in prison, nurses are ideally positioned to take this role further by also intervening in the community towards addressing the socially significant health issues which plague released offenders not in contact with the criminal justice system. Consequently, the use of nurses in the provision of health and social care interventions to released

offenders in the community is a strategy which could increase equity in access to healthcare, reduce reoffending and improve both the health and life chances of these individuals.

1.5 Research question, aims and objectives

This study is entitled “Mapping The Offender Health Pathway: Challenges and Opportunities for Support Through Community Nursing”. It was commissioned by the Burdett Trust for Nursing with ethics approval received from the University of Wolverhampton School of Health and Wellbeing Ethics Committee and the Ministry of Justice via the National Offender Management Service. The study adopted a nursing focus due to the funding requirement of the Burdett Trust for Nursing which dictated that the study explore the provision of a nurse led intervention. As articulated in the ethics application (Appendix I), the aim of this study was to map the released offender health pathway in order to identify ‘touch points’ in the community where nurse led interventions could be delivered. The study key question was: ‘Where and how can health interventions be provided by nurses to released offenders now living in the community’?

In answering this question, the study was designed to map the released offender health pathway towards identifying points in the community where nurse led interventions could be delivered in a manner and way which would be ethical, non-stigmatising and agreeable to offenders in the community. The study consequently aligned this overarching aim to the following objectives:

1. To explore and document current levels of support aimed at improving the health of released offenders living in the community.

2. To critically analyse key documentation (policies and procedures, statutory guidance) on the provision of health services for released offenders in the community.
3. To describe and explain the offender health journey on release of the offender from prison into the community.
4. To gather and interpret the views, opinions and lived experiences of released offenders in the context of their uptake of health services in the community.
5. To evidence the opinion of individuals who have been in contact with released offenders with regards to released offender uptake of health services in the community.

1.6 Study contribution to knowledge

This study contributes to knowledge by making original contributions on the basis of the study methodology, the wider context of offender health and in addressing the study research question. The study contributes to the evidence on community based management of the health of released offenders by uncovering where and how they would like their health needs to be addressed in the community. It also builds the capability of nurses to work with released offenders and multidisciplinary providers in the community.

1.7 Overview of chapters

This thesis will be structured under the headings of The Silences Framework (TSF) (Serrant-Green, 2011). To present a brief description of the chapters in this

dissertation; Chapter Two provides the theoretical framework for this thesis and accompanying philosophical standpoints which underpin this study. Chapter Three contextualises the reality of ex-offender health through a review of the literature and will highlight foundational studies conducted in the past on this issue and important historical events that allude to why the research problem exists in its present context. Chapter Four presents my reflection on the 'Silences' arising out of the relationship between myself, the research subject and the research participants. Consequently, this will ultimately inform the overall study design and the methods adopted in collecting data. Chapter Five explains the methods adopted in this study and provides a detailed account of how participants were recruited and data collection instruments were administered. Additionally, this chapter also presents potential problems which were encountered during the conduct of the research and issues to do with the overall trustworthiness and credibility of the study. Chapter Six presents the analysis of the study while Chapter Seven discusses the findings of the study. Chapter Eight concludes the study through a recap of the Silences uncovered and recommendations for addressing these.

2. CHAPTER TWO – STUDY THEORETICAL FRAMEWORK

2.1 Introduction

This chapter is oriented towards rationalising how this study constructs truth in the search for knowledge. The theories and concepts that are relevant to this study are explored in an attempt to connect the theoretical framework to existing knowledge. The sole intent of this chapter is to discuss the framework in which this study is situated. This chapter presents the general nature of the research perspective which influenced this study and an explanation of the theoretical framework underpinning the study while concurrently exploring the issues which influenced the adoption of the aforementioned framework. Finally, this chapter concludes with an overview of the several stages of the study theoretical framework.

2.2 Research perspective

Whilst the literature on offender health abounds with evidence detailing the adverse health and health needs of current offenders, this level of interest does not extend to offenders who have been released from prisons into the community (Eshareturi *et al.* 2014). In England and Wales, once released into the community, it is assumed although incorrectly that these individuals will integrate into mainstream society and will access health and social care services through ‘normal’ channels (Hucklesby and Hagley-Dickinson, 2007). While this may be the case for some offenders, on the contrary, this does not apply to most released offenders (Moore, 2012). Moreover, this model of societal assumption towards reintegration is conceptually and ideationally flawed because it presupposes a return to wider society without acknowledging the complex interaction of factors and variables that make up post-

prison experience (Moore, 2012). Accordingly, the Social Exclusion Unit in 2002 raised concerns over prisoners' needs post-release and drew attention to the failure of many agencies to respond appropriately (Social Exclusion Unit, 2002). More recently, the same concerns were raised by the Bradley review (2009) and the Continuity of Access Study (Byng *et al.* 2012).

Historically until fairly recently, politically, the focus of government post release for offenders has been on desistance, which is the cessation of offending, and not necessarily on health and wellbeing (Her Majesty's Inspectorate of Prisons for England and Wales, 1996). Nonetheless, as evidenced by the Joint Prison Service and National Health Service Executive, Working Group publication entitled *The Future Organisation of Prison Health* (1999), there has increasingly been an acknowledgement in policy circles of the potential for improvement in offender health to impact on desistance from crime. Yet, contradictorily and presently in England and Wales, no National Health Service (NHS) or Department of Health (DH) guidance exists which is dedicated and targeted at the commissioning of health services for released offenders not in contact with the criminal justice service (Department of Health, 2011).

While it is acknowledged that release from prison is a critical opportunity for interventions to achieve socially desirable outcomes by reducing community deterioration and disruption and achieving public health goals, the state of research knowledge on the health needs of released offenders in the community is almost non-existent in the UK (Eshareturi *et al.*, 2013). Moreover, the lack of research on the most appropriate points in the community to deliver health and social care interventions to released offenders and the consistent uni-dimensional presentation of research findings from the perspectives of professionals elicits a feeling of unease

about conducting research within a tradition where the voices of the researched are not being heard (Eshareturi *et al.* 2013). In addressing this and by means of the theoretical framework adopted herein, this study thus intends to uncover how community based nurse-led health interventions can be provided for ex-offenders in a way which would be meaningful to practice and informed by the lived experience of ex-offenders in the community.

Narratives from ex-offenders are indicative of the considerable health needs that plague them in the community. These individuals indicate that on release, their life course trajectory includes cycles of future imprisonment, economic hardship and poor mental and physical well-being (Arditti and Parkman, 2011). The evidence indicates that their health is complex and not understood by many in the wider community which has led to the lack of interventions designed to address their health needs on release into the community (Marlow, 2008; Norman, 2010). Also, many released offenders are not registered with a general practice which makes follow-up care and integration into the wider multidisciplinary teams that support healthcare difficult (Norman and Parrish, 2002). The reluctance of this group to trust health agencies and the stigma they associate with accessing health services to a large extent further contributes to their poor uptake of health services post-release (Crow, 2001; Hucklesby and Hagley-Dickinson, 2007; Wildeman 2012).

This poor uptake of care by these individuals in the community led to the adoption of the ontological position that improvement in ex-offender health could be achieved through the provision of nurse led community based health interventions. This position is informed by evidence which indicates that nursing is uniquely positioned to develop prevention, intervention, and treatment strategies for offenders before, during, and after imprisonment (Maeve 2003; Wildbore, 2004; Norman and Walsh,

2014). Consequently, this study is ontologically situated in the belief that nurses are uniquely positioned to initiate and sustain contact with ex-offenders intervening at points of greatest need in the community.

Whilst the health needs of ex-offenders in the community does indeed exist as a reality and ontologically has existence (Jarrett, Adeyemi and Huggins, 2006; Kariminia *et al.* 2007; Van Doreen *et al.*, 2011), it is difficult to generalise as these health needs are manifest differently in ex-offenders and as such could be said to have multiple realities depending on who is defining it and in what context. Therefore, epistemologically, the generation of knowledge about the reality and/or lived experience of the health of community based ex-offenders would necessitate an anti-essentialist perspective that is interpretive in nature. In this context, the social worlds of ex-offenders are governed by multiple truths which are contextually situated (Binswanger *et al.* 2011). Therefore, community based ex-offenders each have their own subjective health experiences. Taken together, these individualised description leads to 'truth'. This position influenced the adoption of the 'Silence Framework' as the theoretical framework underpinning this study. Crucially, this framework seeks to acknowledge and redress the balance of power relating to 'what and whose' experience counts in a research study (Serrant-Green, 2011). In this context, it is the intent of this study to arrive at what constitutes truth about the provision of a nurse led intervention from the lived experience of community based ex-offenders.

2.3 Silence Framework and its theoretical underpinning

The importance of a theoretical framework cannot be overemphasized as it is the structure around which research is conceived, designed and implemented (Anfara and Mertz, 2006). Thus, it is the 'birthing point' for the methodology and methods that will be used in a research study (Crotty, 1998). Although no definite rule exists as to how a theoretical framework should be selected, Crotty (1998) posits that a key criterion in conceptualizing a theoretical framework is that it must clearly address the 'what' question: what exactly is the study trying to achieve? In other words, a crucial function of a theoretical framework is that it helps rationalize the need for a study. In addition, the theoretical framework must also clearly construct the philosophical basis under which research is situated and subsequently link the theoretical with the mechanical component of a research study (Anfara and Mertz, 2006). As this study is aimed at the provision of nurse-led interventions for a marginalized group (ex-offenders), this study adopted The 'Silence Framework' (TSF) as conceptualized by Serrant-Green (2011) as the framework of choice. This framework is ideally suited for researching issues which are little researched, silent from policy discourse and marginalized from practice (Serrant-Green, 2011).

This study adopts an interpretative research paradigm which views the truth as multiple realities that are socially constructed by the individuals researched. Fundamentally, this study construes the concept of truth as a relative construct and posits that ex-offenders irrespective of prior imprisonment all have their own unique experience of what they call truth. This approach views every invocation of experience as contextual and historically situated. In this context, the Silence Framework is situated as an anti-essentialist framework which is designed to explore individual areas of experience by valuing individual interpretations of events

(Serrant-Green, 2011). As an anti-essentialist framework, the focus here is to at all times, seek to arrive at reality through an appreciation of the meanings ascribed to events by the individuals concerned (Denzin and Lincoln, 1998). By so doing, this study uses The Silences Framework to focus on the research participants in an 'individualistic way' towards arriving at useful group based conclusions which could be applied to ex-offenders residing in the community.

This approach further aligns itself within the criticalist paradigm to conducting research which endorses an action-oriented methodology. Lincoln and Guba (2000) suggest that this 'action' could take the form of redressing power imbalances which could give voice to individuals who were previously marginalized by policy or practice. Along this line, TSF seeks to explore areas of research which are under-researched or historically and/or politically undervalued, absent or invisible (Serrant-Green, 2004), which indeed, is the case with ex-offender health. However, it is important to note that by adopting this paradigm, this study acknowledges that the importance of the issue being researched is relational. The issue of ex-offender health could be important to ex-offenders and perhaps, the medical practitioners who consistently encounter those using medical emergency services in a crisis led way. However, this issue is relatively 'silent' in the consciousness of the greater majority of society, and absent from the available evidence base where it has failed to have a wider impact on shared aspects of health.

Nonetheless, in adopting both an anti-essentialist perspective and a criticalist paradigm, TSF as adopted herein focuses on exploring the marginalized nature of ex-offender health in order to uncover hidden perspectives with regards to community based delivery of health interventions. Accordingly, TSF as used here seeks to uncover 'Screaming Silences' which are situated in the subjective

experiences of ex-offenders known as the 'listener' and the social and personal context in which these experiences occur. The concept 'Screaming Silence'

reflects how an issue, as experienced by the listener, 'screams' out to them in relation to their health, because of its relationship or impact in their reality. Conversely, the same issue may be relatively 'silent' in the consciousness or experience of the greater majority in society, or absent from the available evidence base where it fails to have wider impact on shared aspects of health (Serrant-Green, 2011, p.349).

Therefore, Screaming Silence as a concept acknowledges and seeks to give voice to the experiences, subjects and issues which are often hidden, devalued or silenced. In addressing these Silences, The Silences Framework is associated with the concept of marginal discourses. Marginal discourses are labeled as such as they are less prioritized by policy and frequently positioned as being far removed from what society considers to be 'normal' (Foucault, 1972; Ifekwunigwe, 1997; Afshar and Maynard, 2000). In contradiction to hegemonic discourses, these discourses owe their importance predominantly to the harshness by which they are marginalized and opposed by mainstream society (Tremain, 2008). This study is closely aligned with this concept as it locates marginal discourses in how policy and practice addresses the health needs of ex-offenders. On the one hand, health policy in England and Wales does not recognize ex-offenders as a group in need of unique support on release from prison. On the other hand, there is a lack of statutory backing to enable practitioners to identify and care for these individuals as a unique group on release from prisons into their local communities. Therefore, their exclusion from policy and practice justifies their categorization as marginalized. Please see Figure 1 for a diagrammatic representation of the study research framework.

Anti-essentialist perspective

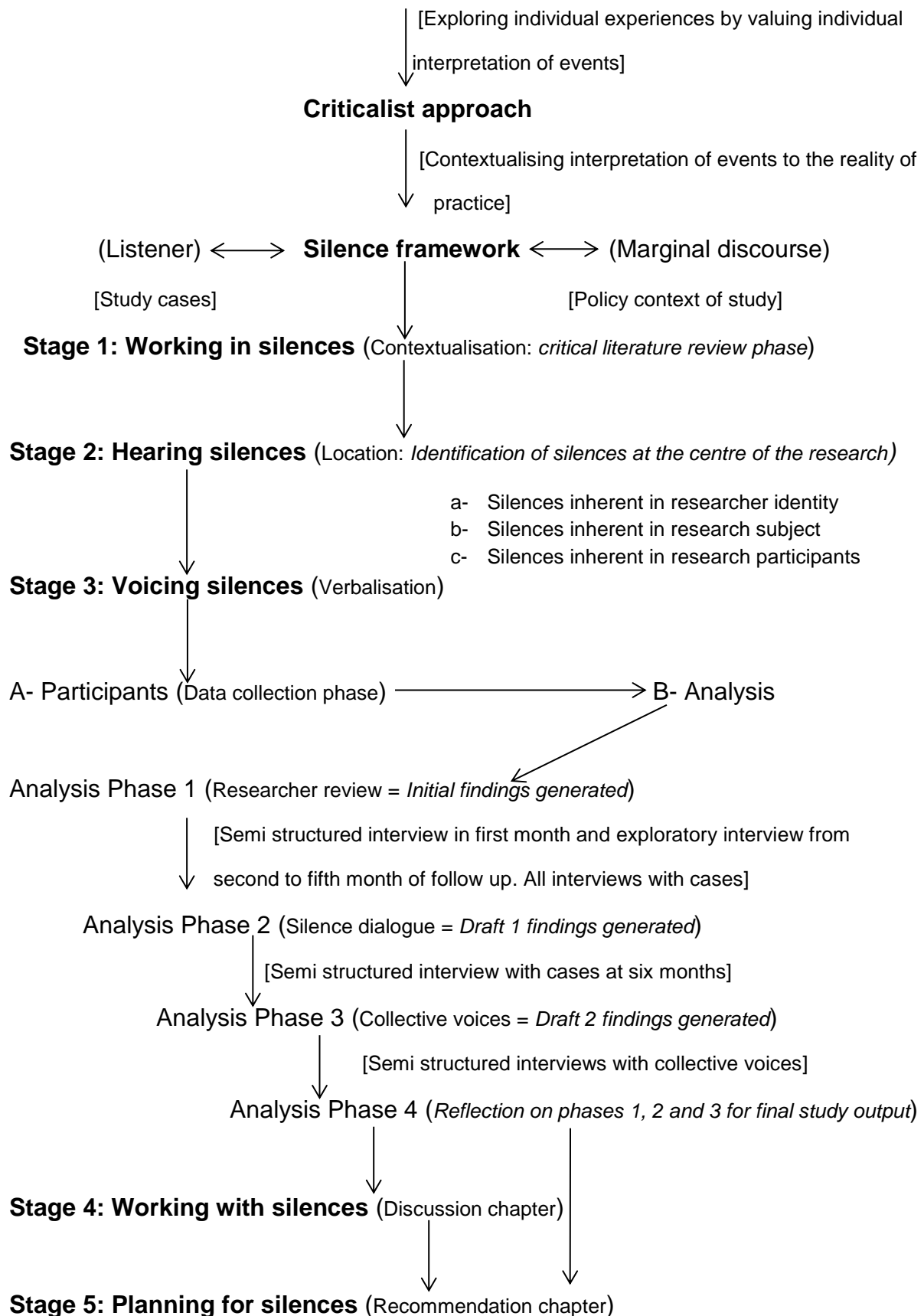


Figure 1. Study research framework

2.3.1 The Silences Framework

The Silences Framework is comprised of four core stages which guide the research activity from conceptualization of the research question to the production of the research findings. The four core stages are:

- Stage 1: Working in ‘silences’
- Stage 2: Hearing ‘silences’
- Stage 3: Voicing ‘silences’
- Stage 4: Working with ‘silences’

Importantly, The Silence Framework also has an additional fifth stage which is particularly useful where the research outputs require the production of an action plan for service delivery or community action (Serrant-Green, 2011). This fifth stage is applicable to this research and forms the recommendation chapter of this study.

This fifth stage is:

- Stage 5: Planning for ‘silences’

A diagrammatic representation of The Silences Framework as tailored for use in this study is shown in Figure 2.

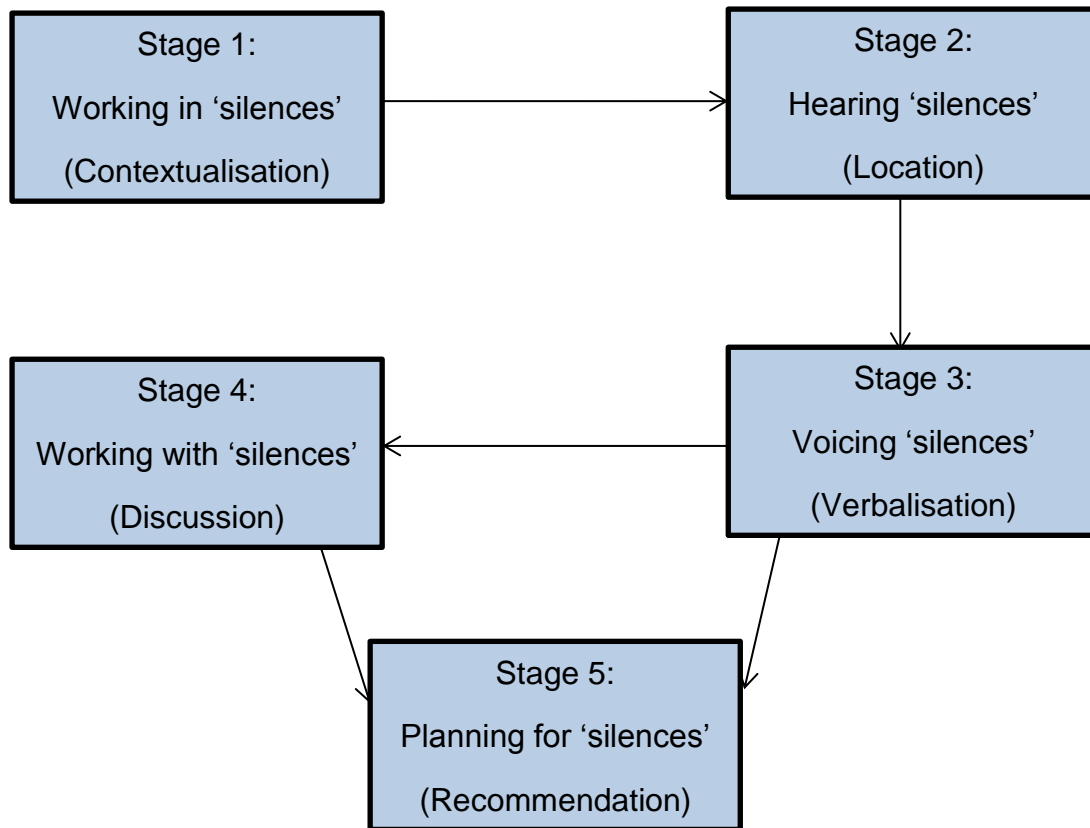


Figure 2. The Silence Framework. Adapted from Serrant-Green (2011)

Stage 1: Working in 'silences'

Towards comprehending the Silences around the health and well-being of ex-offenders in the community, it is important to consider the wider social and political context in which their lives are lived (Freshwater *et al.* 2012). The first stage of this framework thus begins with an identification of these individuals and a contextualization of their lived experiences. This stage sets the context for the research through a critical literature review. The emphasis placed on context is necessitated by the fact that even independently of individual narrative, the context or social situations surrounding a narrative must be understood to grasp the significance of the experience relayed (Maginn, Thompson and Tonts, 2008). In this

sense, an exploration of context is crucial because it juxtaposes experience with time. Therefore, for meaning to be given to experience, the time space in which it occurs must be understood (Altheide, 1996).

On this basis, the literature review conducted herein was aimed at identifying the range and scope of existing knowledge relating to ex-offender health and the policy context in which this study was conducted. Importantly, this review also highlights foundational studies conducted in the past on this issue and important historical events that allude to why the research problem exists in its present context. The rationale for this contextualization was informed by the need to situate the 'realities' of ex-offenders within 'present day' England and Wales. In exploring the real world in which this research occurs, this phase hopes to expose the Silences which necessitated the need for the study. As an outcome of this phase, the possible gains of conducting the study will be presented in light of why this study is topical and crucial.

Stage 2: Hearing 'silences'

In line with the theoretical underpinnings of the Silence Framework which maintains that individual description of truth is socially constructed and informed by the lived experience of the individual (Serrant-Green, 2011), this stage sets out to identify the 'Silences' associated with this research towards ensuring that this study accurately identifies the silence being heard by the study 'listeners' (ex-offenders). The key point in this stage is that it is the 'listener' who ultimately lives with the uncovered silence and therefore, the listener's construction of this silence is considered to be the truth. This stage therefore considers the researcher, the research participants and the subject of interest as existing in an interdependent relationship within the

context of the research set out in Stage 1. In this stage, the research subject will be explored through the lens of the research participants. In addition, this stage will also provide an acknowledgement and a reflexive account of how the researcher's world view came to bear on the study construction of the research subject, research participants and analysis of generated data.

Completing this second stage therefore requires a reflection on the 'Silences' arising out of the relationship between the researcher, the research subject and the research participants (Serrant-Green, 2011). Three aspects of the 'Silences' are presented in order to provide an insight into the nature of this relationship. These aspects underpin and will ultimately inform the overall study design, data collection and analysis as well as any subsequent recommendations arising out of the findings of this study. These aspects are the possible 'Silences' inherent in researcher identity, the research subject and the nature of the research participants. Importantly, the rationale for this stage lie in exposing the thinking and decision pathways through which the 'Silences' addressed in this study were located and made explicit while concurrently acknowledging that the researcher remained the conduit through which these uncovered Silences were heard, identified and prioritized.

a- Researcher identity

In any study utilising The Silences Framework, active engagement must be preceded by an identification of self by the researcher (Serrant-Green, 2011). This identification of self is crucial as it forms the central mechanism through which all other 'Silences' are viewed. In doing this, the researcher locates self within the study towards providing a platform which affords potential readers the opportunity to step into the study through the researcher's lens. Towards achieving this, the reader is assisted in this process through a provision of the thought process underpinning the

study and the issues which influenced the decision to undertake this piece of work. Importantly, the researcher also situates prior biases and beliefs on the research subject in this phase.

b- Research subject

This phase of the second stage is concerned with the identification of the specific issue/s inherent in the research subject that qualifies it as being in need of research. This phase clearly identifies why the healthcare of ex-offenders is 'sensitive' and in need of research attention.

c- Research participants

This is the final phase of the second stage of the Silence Framework. This phase involves explicitly identifying missing evidence relating to the marginalised perspectives of the study participants. Through an exploration of available evidence, this phase identifies the Silences arising from the marginalized perspectives of ex-offenders with regards to their access to community delivered health interventions.

Stage 3: Voicing 'silences'

This stage encompasses the active data collection and analysis phase of the study and is oriented towards exploring the Silences identified in both stage 1 and 2 from the perspectives of key players in the research. As such, this stage juxtaposes the views and experiences of ex-offenders with those of individuals who encounter them in practice towards exploring the Silences uncovered in stages 1 and 2. In doing this, this stage addresses the operational issues inherent in conducting this study using TSF. Consequently, this stage addresses the choice of method, the manner and way the study participants were identified and recruited and the approach to collection and analysis of data.

1- Methods/data collection

The methods incorporated in a study utilising The Silences Framework are informed by the research design which is most suited to exploring the aims and objectives of the proposed study (Serrant-Green, 2011). Accordingly, a qualitative case study design was adopted in addressing the aims and objectives of this study. This section explores the data collection method in depth and the rationale for its adoption in the context of the Silences which were explored.

2- Participants

At the heart of the Silence Framework is the drive to locate and hear the 'Silent Voices' embedded in a particular issue. In this context, it is in the direct exploration of participant experiences that The Silences Framework makes its contribution to knowledge (Serrant-Green, 2011). This section presents the research participants whose Silences were explored and the criteria which qualified them for inclusion in this study.

3- Analysis

The method of analysis in the 'Silences' Framework, just as for conducting data collection, is driven to a great extent by the need to address the study aims and objectives (Serrant-Green, 2011). Towards framing the limitation of this study, this phase commences by restating through a brief summary, the researcher identity and inherent biases which existed at the data collection phase and which will continue to shape the outcomes from the analysis. The rationale for adopting this approach is to provide reviewers of this study with the appropriate tools to enable them arrive at an informed decision on the trustworthiness of this piece of work.

The process of analysis using The Silences Framework has four phases and is cyclical, as seen in Figure 3.

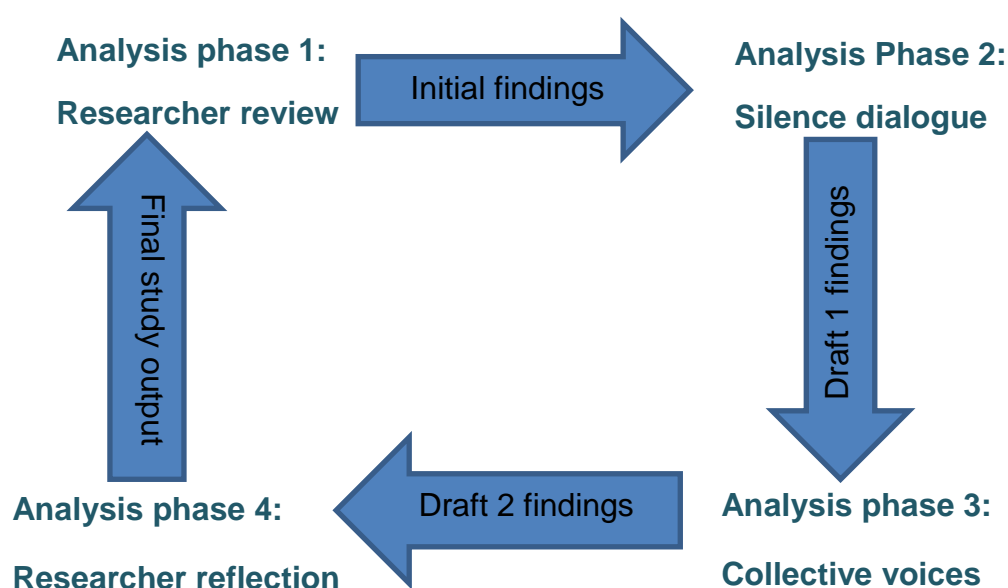


Figure 3: Representation of the phases of analysis.

Phase 1 began with analysis of the data collected by the researcher with reference to the research question. This phase is referred to as ‘researcher review’ and is comprised of the semi structured interview conducted with participants in the first month of contact and the exploratory interviews which were conducted with participants from the second to the fifth month of contact. At the end of this phase, the initial findings from the analyses of these interviews led to the generation of the initial findings. These initial findings led to the development of the semi structured interview questions which were discussed with participants at the sixth month.

At the conclusion of analysis Phase 1 and the production of the study’s initial findings, analysis then moved on to Phase 2 which entailed a review by the study listeners (ex-offenders) of the initial findings provided in Phase 1 by the study researcher. This phase entailed the semi structured interview conducted with participants at six months. This phase of analysis is referred to as the ‘silence

dialogue' primarily due to the fact that the intent of this phase was to ensure that the voices of the researched group were not further silenced, and the intent of the researcher to ensure that the researcher's practice did not unwittingly mitigate against uncovering the Silences heard by the study listeners. Following the 'silence dialogue' the researcher revisited the initial analysis made in analysis Phase 1 to incorporate more detailed second level analysis, utilising any feedback or comments from the 'silence dialogue' around the initial findings. At the end of this second level analysis, draft 1 findings were generated as outputs and taken forward to the next phase of analysis. These draft 1 findings led to the semi structured interview questions which were discussed with members of the collective voices.

Analysis Phase 3 commenced after the production of draft 1 findings (semi structured interview questions to be asked to members of the collective voices) and involved the analysis of the scope and diversity of the evidence generated via the silence dialogue. The objective here was to sample the opinion of individuals in the social network of ex-offenders or others whose social, cultural and/or professional situation impacts on the lived experience of ex-offenders in order to add, corroborate or refute some of the issues presented as draft 1 findings. These included the representation from groups or individuals identified as part of the context in which the 'Silences' identified in stage 1 exist.

At the conclusion of this phase (semi structured interviews with members of the collective voices), draft 2 findings were generated which gave an insight into the potential generalizability of the research findings and the collective voices reflection on the Silences uncovered in the silence dialogue. An additional aspect of the exploration of the findings here included the reflection by this group as to the 'Silences' they consider still exist or remain unchanged as a result of the study.

These reflections served to provide additional insights to inform the fourth phase of the overall 'Silences' framework.

The fourth phase of analysis involved a reflection by the researcher on the findings which emerged from all the phases of analysis which led to the study final outputs. These reflections are discussed in the fourth stage of this study (Working with silences) and the final study outputs are discussed in the fifth stage of this study (Planning for silences).

Stage 4: 'Working with silences'

This is the discussion phase of this study. Via the contributions obtained during the 'silence dialogue' and from the 'collective voices' as well as outputs from Phase 4 of Stage 3, this stage will contextualise the findings generated from the aforementioned phases to the initial aims and objectives of the study.

Stage 5: Planning for 'silences'

This stage addresses the pre-existing Silences uncovered in all previous stages of the study and sets out options for addressing them as contextualised by the study participants. This stage will also set out recommendations for the provision of nurse-led interventions to ex-offenders in the community in a manner and way which is ethical and informed by the study participants. In addition, detailed reflections on the theoretical contributions and pragmatic gains which arose as a consequence of conducting this study using TSF will also be provided. In providing these, the extent to which this study can be generalised will also be presented alongside the probable 'risks' that could arise from acting on the suggested research findings. Finally, this stage will conclude with a reflection on the possible impact of the research findings on the current context of ex-offender health as presented in Stage 1 and the

'Silences' to be heard as a result. The rationale for this reflection is to ensure that the evidence generated by this study while addressing some existing gaps, concurrently informs the context in which further research in this area will occur.

3. CHAPTER THREE – WORKING IN SILENCES (Silences-Stage 1)

3.1 Introduction

This chapter presents a review of the literature on offender health with particular emphasis on the post-imprisonment phase. Critical points of current knowledge will be explored towards highlighting where the gaps are in knowledge. The intent of this chapter is to set the tone for this study by contextualising the wider social and political context which influences the uptake of healthcare for offenders post release. Accordingly, this stage is oriented towards painting a picture of the health profile of released offenders and rationalising the need for support. This chapter will begin by discussing the search strategy employed. This will be followed by discussing according to themes; issues which are pertinent to ex-offender health. Finally, the chapter will conclude by recapping the major points discussed with a view to relating how these inform the need for this study.

3.2 The search strategy

My interest in this study developed from the general debate around the continuity in access to healthcare for offenders on release from prison and the resultant implication of this to the practice of public health. This formed my basis for exploring the literature. A detailed search was done to locate the most up to date Government document on the provision of healthcare for offenders in England and Wales using computers to search available databases via the internet. Information on issues discussed herein was also sought from journals, policy textbooks and in-some cases 'grey sources'. The search process entailed a systematic approach applying explicit procedures and reflective processes as suggested by Rumsey (2004) in identifying

and reviewing articles. A three-step search adopted from Glatthorn and Joyner (2005) was used in the search for literature. These included a broad scan of the literature, a focused review, and finally the comprehensive critique. This three step approach was completed as follows: First, a preliminary search was performed to establish boundaries for this research. This assisted in defining both the breadth and depth of this study in order to retain the research within the defined topic. This preliminary phase relied chiefly on reviews of published works, in order to help narrow down the research problem. Secondly, a focused review was carried out, using databases which are discussed in Appendix III. Finally, using all available sources, research that had a direct bearing on this work was identified. This is covered in the 'grey search' section which is discussed in Appendix III.

Subsequently, and in order to establish rigour, already established and recognised standards were utilised to weigh all relevant materials collected as recommended by Lincoln and Guba (1985). Thus, a comprehensive critique, which involved validity, reliability and conformability checks, was conducted using guidelines from the Critical Appraisal Skills Programme on Qualitative Research (Public Health Resource Unit, 2006). Additionally, the suitability of the research approach for answering the research question was examined. This process was performed to assess the literature, towards establishing that this research was done rigorously and the findings reached were credible.

3.3 Themes and current state of knowledge

The themes discussed emerged based on exploration of the literature as well as discussions held with members of my supervisory team, colleagues in the School of

Health and Wellbeing from the University of Wolverhampton who work as practitioners in the field of offender health and individuals who work in the Criminal Justice System in England and Wales. This enabled themes to emerge gradually which enabled a systematic approach to be taken. Thus, it was a grounded approach, inevitably influenced and assisted by personal knowledge around the research area. Presented below are the key themes that emerged from the review of literature. These key themes include: the problem of constructing meaning inherent in the use of the term 'ex-offender', the criminal justice system in England and Wales, the prison estate in England and Wales, the social exclusion of offenders, adverse health of offenders, health needs of offenders returning to the community, ex-offender health seeking behaviour, released offender barriers to accessing health services and the political context of offender health in England and Wales.

It is important to note that not all studies included in this review were UK based studies. Whilst it is acknowledged that the funding and operational structure of the health system in the UK is comparatively different to the health systems applicable internationally, this study nonetheless includes international evidence in corroborating the facts presented herein. The rationale for this inclusion is underpinned by the fact that the health histories of ex-offenders often follow similar trajectories irrespective of the manner and way the health system is structured in their resident country (Butler *et al.* 2004; Freudenberg *et al.* 2005; Biswanger *et al.* 2011; Byng *et al.* 2012).

3.3.1 *The criminal justice system in England and Wales*

In England and Wales, The Attorney General fulfils the role of chief legal adviser to the government and superintends the principal prosecuting authorities within England and Wales which are the Crown Prosecution Service (CPS) and the Serious Fraud Office. The Attorney General also has overall responsibility for the Treasury Solicitor's Department, the National Fraud Authority and Her Majesty's Crown Prosecution Service Inspectorate, and fulfils a number of independent public interest functions (CPS, 2014). The Ministry of Justice has responsibility for different parts of the justice system which include: the courts, prisons, probation services and attendance centres. Its work spans criminal, civil and family justice, democracy, rights and the constitution (Ministry of Justice, 2014). The priorities of the Ministry of Justice are to reduce reoffending by using the skills of the public, private and voluntary sectors, reduce youth crime by putting education at the centre of youth justice, build a prison system that delivers maximum value for money, reduce the cost of legal aid, improve the way the courts are run and put the needs of victims first (Ministry of Justice, 2014).

The administrations of civil, family and criminal cases are done in courts in England and Wales (Ministry of Justice, 2014). Advocates representing the Crown Prosecution Service prosecute the majority of the criminal cases that are heard within the magistrates' courts and the crown courts. Magistrates' courts deal with the less serious criminal offences. Youth courts are special magistrates' courts which deal with all but the most serious charges against people aged between 10 (the age of criminal responsibility) and under 18. Crown Courts deal with the most serious offences, which are triable by judge and jury (CPS, 2014). There are 43 police forces across England and Wales responsible for the investigation of crime, collection of

evidence and the arrest or detention of suspected offenders. Once a suspect is held, in minor cases the police decide whether to caution them, take no further action, issue a fixed penalty notice or refer to the CPS for a conditional caution, or in the more serious cases, send the papers to the CPS to decide upon prosecution (CPS, 2014). The National Offender Management Service provides administration of correctional services in England and Wales through Her Majesty's Prison Service and the Probation Service. Prison and probation services ensure the sentences of the courts are properly carried out and work with offenders to tackle the causes of their offending behaviour (CPS, 2014).

3.3.2 The prison estate in England and Wales

England and Wales has the highest imprisonment rate in Western Europe with about 1.3 million adults sentenced in courts each year and an imprisonment rate of 150 per 100,000 of the population (Williamson, 2006). Scotland has a rate of 146 per 100,000. France has a rate of 101 per 100,000 and Germany has 80 per 100,000 (Prison Reform Trust, 2013). The minimum age of criminal responsibility in England, Wales and Northern Ireland is 10 years. It compares to 12 years in Canada, 13 years in France, 14 years in Germany and China, and 15 years in Sweden. In Scotland the age of criminal responsibility is eight years, but the minimum age for prosecution is 12 (Jacobson and Talbot, 2009).

In 2000, there were 64,602 people in prison, a figure that has been slowly increasing (Ministry of Justice, 2010c). Between 1995 and 2009, the prison population in England and Wales grew by 32,500 or 66% (Ministry of Justice, 2009). Of a million active offenders, 100,000 have three or more convictions and are responsible for half

of all crimes committed in the UK (Williamson, 2006). Although offenders are predominantly male, (over 80%), the arrest of females is increasing disproportionately with imprisoned females having more than doubled in the last decade (Women Resource Centre, 2010). Offenders are characteristically young; two fifths of arrests in 2005 were of people under the age of 21 and the number of arrests amongst this age group is rising (Williamson, 2006). There is a disproportionate involvement of offenders from black and ethnic minorities within the prison estate in England and Wales, and in June 2004, the percentage of foreign national women in prison made up 25% of the total female prison population (Williamson, 2006).

The prison system as a whole has been overcrowded every year since 1994 and at the end of March 2013, 69 of the 124 prisons in England and Wales were overcrowded (Ministry of Justice, 2013x). It is recognised that in England and Wales, prisons have a poor record for reducing reoffending, with 47% of adults being reconvicted within one year of release. Moreover, for those serving sentences of less than 12 months this increases to 58% and nearly three quarters (73%) of all individuals under 18 years are reconvicted within a year of release (Ministry of Justice, 2013z). The proportion of the sentenced prison population serving indeterminate or life sentences increased from 9% in 1993 to 19% in 2012 (Ministry of Justice, 2013q) and the average annual overall cost of a prison place in England and Wales for the financial year 2011-12 was £37,648 (Ministry of Justice, 2012z). Reoffending by all recent ex-prisoners in 2007-08 cost the economy between £9.5 and £13 billion with as much as three quarters of this cost attributed to former short-sentenced prisoners: some £7-10 billion a year (National Audit Office, 2010). However, according to the National Audit Office, there is no consistent correlation

between prison numbers and levels of crime in England and Wales (National Audit Office, 2012).

Between June 1993 and June 2012 the prison population in England and Wales increased by 41,800 prisoners to over 86,000. Almost all of this increase took place within those sentenced to immediate custody (85% of the increase) and those recalled to prison for breaking the conditions of their release (13% of the increase) (Ministry of Justice 2013q). The recall population grew rapidly between 1993 and 2012, increasing by 5,300. This reflected a higher recall rate caused by changes to the law making it easier to recall prisoners, and changes introduced in the Criminal Justice Act 2003 which lengthened the licence period for most offenders (Ministry of Justice, 2013r). Most women entering prison serve very short sentences. In the year ending September 2012, 59% of sentenced women (4,544) entering prison were serving six months or less. This is an increase of 2% from the previous year (Ministry of Justice, 2013r). Most women entering prison under sentence (81%) have committed a non-violent offence. Theft and handling stolen goods accounted for 37% of women entering custody under sentence (Ministry of Justice, 2013n).

On 31 March 2013, 26% of the prison population, 21,462 prisoners, were from a minority ethnic group (Ministry of Justice, 2013n). This compares to around one in ten of the general population (Equality and Human Rights Commission, 2010). Out of the British national prison population, 10% are black and 6% are Asian (Prison Reform Trust, 2013). For black Britons this is significantly higher than the 2.8% of the general population they represent (There is now greater disproportionality in the number of black people in prisons in the UK than in the United States (Equality and Human Rights Commission, 2010). On 31 December 2012, there were 9,880 prisoners aged 50 and over in England and Wales, including 3,377 aged 60 and

over. This group makes up 12% of the total prison population (Ministry of Justice, 2013r). People aged 60 and over are now the fastest growing age group in the prison estate. The number of sentenced prisoners aged 60 and over rose by 103% between 2002 and 2011 (Ministry of Justice, 2012t). Forty two percent of men in prison aged over 50 have been convicted of sex offences. The next highest offence category is violence against the person (26%) followed by drug offences (12%) (Ministry of Justice, 2012t).

Prisons in England and Wales are run by Her Majesty's Prison Service and private sector partners under contract with the National Offender Management Service (NOMS) (National Offender Management Service, 2012). Probation services are provided by Community Rehabilitation Companies (CRCs) and the National Probation Service (NPS). The operating remit of CRCs is to manage offenders in the community sentenced to Community Orders, Suspended Sentence Orders and those subject to licence conditions or supervision requirements. The operating remit of the NPS is to manage offenders who pose a high risk of serious harm to the public (MOJ, 2013zz). Both CRCs and the NPS receive funding from the National Offender Management Service to which they are accountable for their performance and delivery. In turn, the National Offender Management Service is accountable to the Ministry of Justice (MOJ, 2013zz). As of Friday the 22nd of May 2015, the total population of prisoners in England and Wales was 85,744. Of this population, 81,845 were male and 3,899 were female (Ministry of Justice, 2015z).

3.3.3 The problem of constructing meaning through language: released offenders or ex-offenders

Labelling can mould the way individuals lead their lives especially if they are unable to do away with the label in question (Blumer, 1969). Society creates deviance through making rules whose infractions constitute deviance by applying these rules to particular people and labelling them as outsiders (Becker, 1963). Becker argues that deviance is not representative of the act a person commits but a consequence of the application by others of rules and sanctions. Consequently, the deviant is one to whom the label has successfully been applied (Becker, 1963). The criminological labelling perspective is derived from symbolic interactionism which examines how interpretative processes result in situational deviance (Maddan, 2008). This theory posits that an individual takes the 'role of the other' or becomes the 'looking glass self' in all social situations (Blumer, 1969). In this context, a complete picture of crime or deviance must also include society's reactions to it (Maddan, 2008). In reaction to deviants to our norms as a society, a label unwittingly associates an individual with a deviance whether or not the deviance could become manifest in the present or future (Thompson, 2004). Moreover, the evidence is clear and suggests that a deviant label can lead to further deviance which may in turn, have the effect of entrenching criminal identities (Thompson, 2004; Maddan, 2008; Robbers, 2009). In this sense, once an individual has been successfully labelled as an ex-offender, the label attached may become the dominant label or 'master status' which may become more important than all the other aspects of the individual (Becker, 1963).

Labels such as 'ex-offender' may indeed be stigmatising and may not achieve the aim of creating safer societies since the practical impact of this label and the very fact of being so labelled may have negative connotations (Harrison and Schehr,

2004). With this label comes the baggage of distrust, lack of credibility and an association with risk, harm and reoffending (McNeill, 2012). The status of ex-offender although just a part of an individual's identity, becomes the most prominent defining characteristic for representing self (Farrall, 2013). Evidence is available to suggest that labelling an individual as an ex-offender may at best be ineffective and at worst counterproductive (McNeill, 2012; Farrall, 2013). As opposed to encouraging positive approaches which promote reintegration, the practical consequence of this label appear to be counter-evidential in that it creates a legal barrier which hinders truly successful integration and makes it difficult for ex-offenders to bring normality to their lives (Thompson, 2008). The lived experiences of these individuals indicate that in employment, parental rights, housing, public benefits and student loans, the fact of a criminal record is often the basis for a second, civil punishment (Harrison and Schehr, 2004). Therefore, in using the term ex-offender to construct meaning, a counterintuitive logic appears to be manifest in what the term connotes and what is implied in its use. Consequently, the question must be asked: what exactly is the label ex-offender aimed at achieving? Is it aimed at protecting the public or further demonizing offenders on release from prison?

3.3.4 The social exclusion of offenders

Prisoners are excluded in education. In the UK, a total of 47% of prisoners say they have no qualifications. This compares to 15% of the working age general population in the UK (Ministry of Justice, 2012i). A total of 21% of prisoners reported needing help with reading and writing or ability with numbers, 41% with education, and 40% to improve work related skills (Ministry of Justice, 2012i). Forty one percent of men, 30% of women and 52% of young offenders were permanently excluded from school

(Stewart, 2008) and on release only around 20% of the prison population would gain employment (Ministry of Justice, 2012ii). Forty four percent of prisoners reported living in their accommodation prior to custody for less than a year and 28% had lived there for less than six months. Fifteen percent of newly sentenced prisoners reported being homeless prior to custody and 9% were sleeping rough (Ministry of Justice, 2012iii). Thirty two percent of prisoners reported being in paid employment in the four weeks before custody. Thirteen percent reported never having had a job (Ministry of Justice, 2012 iv). Thirty seven percent of prisoners did not expect to return to their jobs upon release. A quarter of these job losses were because of a reason connected with offending (being sent to prison or because of their criminal record (Ministry of Justice, 2012i).

In 2011-12, just 27% of prisoners entered employment on release from prison. A total of 89% of prisoners had settled accommodation on release (Ministry of Justice, 2012ii). Financial exclusion and debt assessments for 2005 suggest over 23,000 offenders had financial problems linked to their offending (Home office, 2005i). A total of 48% of people in prison have a history of debt (National Offender Management Service, 2007). Almost three-quarters (72%) of prisoners interviewed for a 2010 report by Prison Reform Trust and UNLOCK said they had not been asked about their finances while in prison. A third said they did not have a bank account; of whom 31% had never had one (Bath and Edgar, 2010). Seventeen of the 29 families interviewed for a study: Time is Money commissioned by UNLOCK and the Prison Reform Trust said they were in debt, of whom two thirds said their debts had increased since the imprisonment of their relative (Bath and Edgar, 2010). Over four in five former prisoners surveyed in Time is Money said their conviction made it harder to get insurance and four-fifths said that when they did get insurance, they

were charged more. The inability to obtain insurance can prevent access to mortgages and many forms of employment or self-employment (Bath and Edgar, 2010).

The amount of discharge grant has remained fixed at £46 since 1997 (Prison Service Instruction, 2011). Prisoners who reported being homeless before custody were more likely to be reconvicted upon release than prisoners who did not report being homeless (79% compared to 47% in the first year and 84% compared to 60% in the second year after release) (Ministry of Justice, 2012iii). Prisoners who reported having been employed at some point in the year before custody were less likely to be reconvicted in the year after release than those who did not report having been employed (40% compared with 65%) (Ministry of Justice, 2012i). Sixty eight percent of prisoners thought that 'having a job' was important in stopping reoffending (Ministry of Justice, 2012i). Prisoners who reported having a qualification were less likely to be reconvicted in the year after release from custody (45% compared to 60%) than those who had no qualifications (Ministry of Justice, 2012i).

Amongst the wider determinants of health, housing and education are areas of greatest need in released offenders (Kushel *et al.* 2005). In their study on the health needs of offenders on probation caseloads in Nottinghamshire and Derbyshire, Brooker *et al.* (2008) interviewed offenders and offender managers and identified housing amongst others as an area of significant challenge for offenders that contributed to poor mental health. It was felt that local authorities bowed to wider community pressure not to provide accommodation to released offenders. Moreover, homelessness in released offenders is under-reported with many released offenders 'sofa surfing' with friends or moving between family members which results in being continually dependent on old affiliations and friendships that reinforces offending

behaviour or drug addiction (Brooker *et al.* 2008). Similarly, Arditti and Parkman (2011) in their research examining young men's re-entry after imprisonment indicate that low educational achievement and access to income were factors which influenced and determined help seeking behaviour of released offenders. Importantly, people from black and minority ethnic backgrounds are over-represented in almost all the dimensions of social exclusion described above (Social Exclusion Unit, 2002; Braithwaite *et al.* 2009). They come from intense histories of cumulative disadvantage (Sampson and Laub, 2005), with backgrounds characterized by intergenerational imprisonment and disconnections from major social institutions such as healthcare, housing, and education (Dallaire, 2007; Foster and Hagan, 2007).

A study of young prisoners (aged 25 or less) revealed one fourth had lived in public housing, nearly half had parents or guardians on public assistance, 16% had been in foster care or some other institutional setting growing up, one third had a parent or guardian who had abused alcohol or drugs, and one third had a parent who had spent time in prison or jail (Uggen, *et al.* 2005). Furthermore, these individuals are inundated with problems prior to imprisonment such as substance abuse, mental health issues, family problems, educational deficiencies or disabilities, lack of employable skills, and histories of criminal activity (Altschuler and Brash, 2004; Uggen *et al.* 2005). In addition, due to limited access to, and lack of knowledge of primary health services plus poor lifestyles, ex-offenders on release from prison comprise a large proportion of people using the NHS's urgent healthcare services who are not registered with a GP (Awofeso, 2005; Department of Health, 2007). There were 18 million accident and emergency attendances in a population of 50.1 million in England in 2006-2007 (Brooker *et al.* 2008). This represents 36% of the

general population with the offender population slightly higher than those of the general population (39%). Reasons for this vary from lacking a permanent address, so unable to register with a practice, to lacking mobility, so unable to visit a GP on their own (Mimnagh, 2010).

A research review conducted in England aimed at understanding the health and social care, and the physical and mental health needs of offenders upon release from prison indicated that the health needs of released offenders in the community are significantly greater than the general population (Williamson, 2006). Yet, there is a fundamental mismatch between need and supply. These are important findings and their importance is highlighted by other more widely available health indicators. For example, a study on deaths of offenders in prison and under community supervision showed that the death rates of community offenders are elevated by a factor of four in comparison to the general population and that drugs and alcohol are implicated in nearly half of these deaths (Sattar, 2001). This finding is reinforced by those presented by Williamson (2006) which highlights the disparity between the healthcare received by prisoners in a contained environment with that of offenders released into the community. Indeed, this suggests that not only do released offenders suffer worse health, but they experience extreme difficulty in accessing housing, employment and literacy training which are crucial broader determinants of health.

3.3.5 Adverse health of offenders

Offenders often exhibit risk-taking behaviours such as smoking, drug use and high levels of alcohol consumption that can have negative effects on their health. The

health status of offenders has been compared to those of the general population and suggests that offenders have poor health across a range of conditions compared to the general population (Butler *et al.* 2004). A study examining the continuity in access to healthcare for offenders on release from prison indicated that prisoners experience at least one chronic health condition, many with multiple health problems (Byng *et al.* 2012). The gender difference is also stark; with two fifths of female prisoners and approximately a third of male prisoners reporting a chronic physical condition (Singleton *et al.* 1998). Other health studies have shown that mental illness, cardiovascular conditions, asthma and epilepsy are frequently reported in offenders (Lader, Singleton and Meltzer, 2000; Williamson, 2006). A study investigating the problems and needs of newly sentenced prisoners indicated that over a quarter of newly sentenced prisoners (27%) reported having at least one long-standing physical health problem or disability (Stewart, 2008). In addition, the health of elderly prisoners is increasingly becoming a public health issue (Walsh *et al.* 2014). Compared to their contemporaries in the community, elderly prisoners have a physical health status which is 10 years older (Cooney and Braggins, 2010).

3.3.5.1 Disorders of physical health

Research in the United Kingdom has shown that prisoners commonly experience chronic physical health problems and that the pattern of disease is different from that in the general community. In one study, nearly half of the entire sentenced, male, adult prisoners had some type of long-standing illness or disability (Bridgwood and Malbon, 1995). Very high levels of chronic illness or disability have also been found among young and adult women prisoners (Plugge, Douglas and Fitzpatrick, 2006). From a public health perspective, prison populations have been found to have higher rates of sexually transmitted infections, hepatitis B and C, and human

immunodeficiency virus (HIV) than the general population (Weild *et al.* 1998; Long *et al.* 2001). Mair and May (1997) found that of 1,213 offenders under the supervision of probation services, almost half (49%) said that they currently had, or expected to have, certain long-term health issues or disabilities, commonly musculoskeletal, respiratory and mental health problems. Nearly a third of the sample said that physical health problems limited the work they could do. Hatfield *et al.* (2004) reported on a cohort of 467 residents in probation approved premises within Greater Manchester, finding 19% of the sample had one or more physical health problems. Payne-James *et al.* (2010) examined the general health of detainees in police custody to determine how well health issues were managed. From a sample of 168 detainees, 94 (56%) had active ill health, the most commonly reported problem was depression in 14% of the sample. In terms of addressing their health problems while in custody, 70 of the 94 (74%) with active health problems were in receipt of prescribed medication, but only three (4%) had their medication available at the police station.

3.3.5.2 *Substance abuse*

Levels of drug use are high amongst offenders, with the highest levels of use found amongst the most prolific offenders (Prison Reform Trust, 2013). Over half of the prison population in England and Wales has a drug or alcohol dependence problem (Singleton *et al.* 1998). Poly-drug use is common among offenders entering custody, with opiate dependence and injecting more common among women than men (Department of Health, 2007). Drug-related overdose deaths following release from prison are also of concern, with heroin involved in nearly all drug-related deaths in the two weeks following release from prison, often due to diminished opioid tolerance (Bird and Hutchinson, 2003; Farrell and Marsden, 2005). Sixty four percent of

prisoners reported having used drugs in the four weeks before custody (Ministry of Justice, 2013a). At the end of December 2012, 14% of men and 15% of women in prison were serving sentences for drug offences (Ministry of Justice, 2013r). Of those prisoners who had used heroin on a daily basis, on average women spent £50 per day on heroin compared to £30 for men (Ministry of Justice, 2013a). A total of 19% of those prisoners who said they had ever used heroin reported having used heroin for the first time in a prison (Ministry of Justice, 2013a). With regards to the proportion of detainees in police custody who are drug users, one UK study reported that 69% of arrestees gave urine samples positive for at least one drug; 36% were positive for two or more drugs; and 38% tested positive for opiates and/or cocaine (Bennett and Holloway, 2004). A self-report study of drug users in police custody reported that of 113 participants, 6% knew that they were hepatitis B positive, 20% hepatitis C positive and 4% HIV positive (Payne-James, Wall and Bailey, 2005).

Reliable information about the prevalence of alcohol abuse among offenders within the criminal justice system is limited. This is in spite of figures from wider society suggesting that, in the UK, the impact of alcohol abuse on crime, offending behaviour and public safety is grave enough to attract attention from the government (Williamson, 2006). Yet, every year in the UK there are an estimated 1.2 million incidents of alcohol related violence, 360,000 alcohol related incidents of domestic violence, and 85,000 cases of drunk driving (Prime Minister's Strategy Unit, 2003). A number of studies over time have noted that between 22% and 25% of detainees were reported to be 'drunk' on arrival at UK police stations (Robertson, Gibb and Pearson, 1995; Bennett, 1998; Best *et al.* 2002). It has also been shown that alcohol is an important factor in deaths in police custody. Best and Kefas (2004) reported that of 58 deaths in police custody in England and Wales in two years (2000 and

2001), nearly 40% had been arrested for alcohol-specific offences. Moreover, the arresting officer believed the detainee was drunk in a further 19% of cases.

Newbury-Birch (2008) studied the prevalence of alcohol abuse among 715 offenders in contact with the probation service in the north-east of England and found that 69% of men and 53% of women fitted criteria for an alcohol misuse disorder. Analysis of routinely collected data from the National Probation Service and the Prison Service in England and Wales shows that, from the assessments of 120,000 offenders across 41 probation areas, 37% of offenders had a current problem with alcohol use, 37% were binge drinkers, 32% attributed their violent behaviour to their use of alcohol, and 38% were found to have a 'criminogenic need' relating to alcohol misuse, potentially linked to their risk of reconviction (Moore, 2007). In 44% of violent crimes the victim believed the offender or offenders to be under the influence of alcohol (Home Office, 2011). Of prisoners who reported consuming alcohol in 2012, more men (87%) reported drinking alcohol in the four weeks before custody compared with women (75%). Of those prisoners who reported drinking in the four weeks before custody, 32% said they drank on a daily basis (Ministry of Justice, 2013a). The proportion of the general UK population who reported drinking on a daily basis during the previous year was considerably lower than amongst prisoners - 16% of men and 10% of women (Ministry of Justice, 2013a). Men and women prisoners who reported drinking daily drank an average of 20 units per day. This was equivalent to drinking four bottles of wine or ten pints of beer in a single day (Ministry of Justice, 2013a).

3.3.5.3 Mental health

Skeem and Loudon's (2006) review of relevant research around community-managed offenders indicated that mentally disordered offenders receiving

community supervision were frequently failed by services. Vaughan and Stevenson (2002) conducted a survey which found that mentally disordered offenders were disenchanted with mental health services and were unlikely to seek help themselves. The Healthcare Commission's (2006) review of 50 Youth Offending Teams found that there were still difficulties in younger offenders accessing Mental Health Services. Healthcare workers in these teams became involved in providing healthcare themselves on the basis of what they could offer rather than helping young offenders to access the healthcare they needed. The study by Chitsabesan *et al.* (2006) revealed that high levels of identified needs amongst released offenders were often unmet and that the prevalence of alcohol/drug misuse and suicidality amongst offenders in the community exceed those of the prison population. This study indicated that recently-released offenders constitute a particularly vulnerable group in terms of substance misuse and mortality. The results of this study were corroborated by those of Brooker *et al.* (2008) which indicated that community managed offenders have disproportionately greater health needs than the general population but less opportunity to access the healthcare services to support these needs.

Singleton *et al.* (1998) conducted a large-scale point prevalence study of psychiatric morbidity in prisoners in England and Wales, reporting rates of probable psychosis of 21% of the female remand population; 10% of the sentenced female population; and 9% and 4% of the male remand and sentenced population, respectively. A total of 17% of male remand prisoners and 21% of female remand prisoners were diagnosed as experiencing a current depressive episode. Seventy eight percent of the male remand population and 50% of the female population were diagnosed as having a personality disorder, the most prevalent being antisocial personality

disorder, identified in 63% of male remand prisoners and 31% of female prisoners. Estimates of prisoners with mental illness requiring immediate transfer into mental healthcare outside of the prison system vary from 3% to 9% of the total prison population (Gunn, Maden and Swinton, 1991; Birmingham, Mason and Grubin, 1996; Brooke *et al.* 1996).

In court settings, Greenhalgh *et al.* (1996), found psychiatric disorders in 77% of court attendees in Leeds. Shaw *et al.* (1999) found serious mental illness (schizophrenia, manic depression and major depression) in 1.3% of defendants who attended court in Manchester from the community. This figure rose to 6.6% in those who had been held in police custody overnight. Of concern was the fact that only 15% of those identified by researchers as being currently mentally ill were identified as such by court staff and subsequently referred to the on-site mental health liaison service. In police custody, Robertson, Pearson and Gibb (1996) studied people held in London police stations during one six-month period, finding that 2.7% had some form of mental illness, while 1.2% overall had serious symptoms. Keyes, Scott and Truman (1998), in a similar study which was aimed at mapping the mental health needs of people in contact with the criminal justice system in London police custody suites identified 1.9% of arrestees as having a mental illness. For offenders on probation, Hatfield *et al.* (2004) noted that probation staff were not trained to identify and assess psychiatric problems but that there were high rates of mental disorder among at least some sections of their clientele. Their study of residents of probation-approved premises found that just over a quarter had a known psychiatric diagnosis, with 41% of these having more than one diagnosis. Nearly 6% had a psychotic illness, 30% had a problem with alcohol misuse and 34% had a problem with drug misuse.

Forty nine percent of women and 23% of male prisoners in a recent Ministry of Justice study were assessed as suffering from anxiety and depression. This can be compared with 16% of the general UK population (12% of men and 19% of women) (Ministry of Justice, 2013g). 25% of women and 15% of men in prison reported symptoms indicative of psychosis (Wiles *et al.* 2006). The rate among the general public is about 4% (Wiles *et al.* 2006). 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody (Ministry of Justice, 2013g). In the 12 months ending September 2012, there were a total of 23,134 incidents of self-harm in prisons, a decrease of 8% compared with the previous 12 months (Ministry of Justice, 2013r). A total of 23% of self-harm incidents occurred within the first month of arriving in a prison - 6% on the day of arrival (Ministry of Justice, 2013r). Women accounted for 30% of all incidents of self-harm despite representing just 5% of the total prison population (Ministry of Justice, 2013r). A total of 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide (Ministry of Justice, 2013r).

3.3.6 Health needs of offenders returning to the community

Released offenders are marginalised in society and tend to fall easily between care systems (Social Exclusion Unit, 2004; Williamson, 2006; Lim *et al.* 2012). Home Office and Prison records as well as death certificates indicate that released offenders living in the community are four times more likely to die than the general male population, a rate that is twice as high as that of imprisoned offenders, and that half of these deaths occurred within 12 weeks of release (Sattar, 2001). Williamson

(2006) attributes this high mortality rate in released offenders to the loss of protective factors associated with imprisonment (diminished access to drugs and alcohol). In addition, a clear link exists between poor health and criminal behaviour (Skeem and Loudon, 2006; Appleby *et al.* 2010). A review of relevant literature concluded that offenders with serious mental illness are twice as likely to fail in community supervision compared to those without mental illness (Skeem and Loudon, 2006). Furthermore, reoffending rates also positively correlate with poor health status (Social Exclusion Unit, 2002), and mentally disordered released offenders who are out of contact with services can be particularly at risk of reoffending (Social Exclusion Unit, 2004).

However, in the last decade, policy drivers such as NHS led provision of healthcare to prisoners backed by considerable investment have generally improved prison healthcare (Department of Health, 2007). A randomised controlled trial on the effectiveness of motivational interviewing by prison staff on the effectiveness of substance use after release for prisoners indicated that the disciplining of life and reduced access to alcohol and drugs in prison afford a protective factor for many offenders (Forsberg *et al.* 2011). Upon release, however, offenders seem to have difficulty accessing mainstream health services and tend to engage with health and social care services in a crisis led way (Awofeso, 2005; Department of Health, 2007). In addition, the paucity of information on the needs of offenders in the community inadvertently contributes to the lack of service provision for them (Solomon and Rutherford, 2007). By way of confirmation, a literature search of principal databases such as: Cochrane Library, DH Data, EBSCO Host Research Database, Google Scholar, Internurse, Medline, Proquest, Ovid SP Database, Science Direct,

Swetswise and Wiley Online Library yielded little research that was specific to addressing released offenders health needs in the community.

Articles were found which referred to this subject but in a way that was coincidental to the primary aims of the respective studies. Moreover, whilst the articles focused on the scale of the problem, there was little in terms of evidence suggesting how the identified problems could be tackled. For instance: Mair and May's (1997) comprehensive interviewing of a sample of 1,213 people on probation caseloads indicated that 49% of the sample had or expected to have a health problem lasting at least six months. The authors contrasted this with figures from the general population and indicated that 46% of male probationers between 16-44 years of age reported long term illness or a disability compared to 26% in a matched age group within the general population. They conclude that there is clear evidence of a higher incidence of self-reported health problems in probationers that are similar to the high rates amongst prisoners and that these rates exceed those found in the general population. A similar study of 60 offenders in a drug court probation programme was undertaken by Hagedorn and Willenbring (2003). They found lower SF36 physical component summary and mental component summary scores that denoted worse subjective health than the general population. The sample group of offenders also reported high levels of anxiety and depressive symptomology that were further confirmed by structured interviews with 15 of the participants.

Hatfield *et al* (2004) undertook a 12 month cohort study of 467 individuals in a probation approved premises. Staff members reported that 25.1% of the offenders had a known psychiatric diagnosis, 34.3% had drug misuse and 30.6% had an alcohol abuse problem. A cross-sectional survey using a needs assessment of 301 young offenders, 150 of whom were living in the community and 151 in custody

indicated that alcohol and drug misuse needs were higher in the community sample (Chitsabesan *et al.* 2006). Similarly, a study using tracking methods and relying upon objective data such as contact with local mental health services (Keene, Janacek and Howell, 2003), identified that 13.6 % of the total probation population were in contact with the local mental health trust with the proportion higher amongst female offenders (19.6%). This study revealed a disjuncture between mental health problems and contact with service. Only 53% of offenders who probation officers had assessed as having poor mental health were in contact with mental health services. The variance in these figures concerning the prevalence and profile of health problems amongst released offenders may contribute to the lack of targeted services dedicated to improving their health in the community. Nonetheless, despite the difficulties inherent in making effective comparisons, all the studies indicate that the physical and psychological pathology of released offenders exceeds that found in the general population and should give rise to concern.

3.3.7 Ex-offender health seeking behaviour

A stigma is a mark or characteristic that designates a person as compromised and constructs boundaries between individuals which could either be passive or active (Austin, 2005). Ideologically, stigma is rooted in the belief that social, economic, and political resources should not be spent on benefiting people whose conditions are the result of their own poor decision making, and that, society's social order should reflect a hierarchy of groups differentiated on the basis of moral distinction (Crandall, 2000). This being the case, at best, it could be said that offenders are accepted back into society on sufferance, on a provisional basis (Evans and Wallace, 2008). Therefore, whatever relief from shame the imprisoned may enjoy while confined in

prison, the stigma reattaches when the convicted is released from the supervision of the criminal justice system (Austin, 2005). The stigma of imprisonment does not only affect the offender in question but also affects their relationships, families and communities (Hawkins, O'Keefe and James, 2010). This stigma is also manifest in their exclusion from opportunities which could otherwise help them address their structural needs towards becoming law-abiding citizens and leading productive lives (Freudenberg *et al.* 2005). Moreover, since ex-offenders return to their own communities which usually are already economically and structurally deprived, their history of imprisonment, individual burden of poor health and huge barriers to accessing social and health services accumulate as hidden retribution on communities with the fewest resources and greatest problems (Hawkins, O'Keefe and James, 2010).

After release from prison, a return to previous patterns of behaviours is common, as is the reappearance of health problems that may have been identified and treated in custody (Kinner *et al.* 2012). Evidence is available to suggest that offenders do not prioritise health above structural needs on release and in the main appear to seek health help only when in crisis (Burgess-Allen, Langlois and Whittaker, 2006; Byng *et al.* 2012). Psychologically, this behaviour may be attributed to the regimented and controlled nature of the prison environment which unwittingly leads the imprisoned to lose the ability to take responsibility for self upon release (Marlow, 2008). The personal agency they once possessed prior to imprisonment may be lost due to imprisonment and the accompanying institutionalisation which is defined as the mechanism by which the imprisoned assumes the culture of the institution (Goffman, 1961).

Haney maintains that for prisoners, this process is often referred to as 'prisonization', which is the coping mechanism for dealing with the deprivations and restrictions of prison life (Haney, 2003b). The imprisoned is inundated with such a network of regulations and rules that their own internal controls may deteriorate over the course of imprisonment leading to becoming accustomed to this loss of independence and becoming reliant upon the institutional structures of their imprisonment (Haney, 2003a; Haney, 2003b). This leads to the experience of severe distress and disorientation upon release from prison which leads to harmful or destructive behaviour and a neglect of self which could be expressed in the use of health services in a crisis led way (Goffman, 1961; Irwin, 1970; Haney, 2003b). Simply put, on incarceration the basic needs of the imprisoned are met by the state. Housing, healthcare and food are often provided. Thus, the imprisoned are not required to act as agents of self as they would normally do in a formal way in society and over time, they lose the ability to do this upon re-entry back into society. Accordingly, the impact on health reality as a consequence of this institutionalisation is the observed use of health services in a crisis led way upon release into the community.

3.3.8 Released offender barriers to accessing health services

The World Health Organisation's (WHO) Health in Prisons Project recognises the integral link between the health of any nation's prison population and that of the population at large, noting that in all countries of the world, it is people from the poorest and most marginalized sections of the population who make up the bulk of those serving prison sentences (WHO, 2003). Individuals entering prison are strictly and swiftly institutionalized to new rules and processes of the prison. Yet at release, there is no comparable orientation to the outside rules and processes of the

community (Haney, 2003b). Released offenders leave a highly structured, closely monitored, non-private environment to enter a socially isolated environment that requires self-regulation, self-control and independent decision making skills (Nelson, Dees and Allen, 1999). This can be shocking and disorienting for the newly released individual causing stress, fear and dysfunctional or destructive behaviour frequently leading to re-arrests and re-incarceration (Marlow, 2008; Woodall, Dixey and South, 2013).

It has been argued that many released prisoners re-enter their communities with limited pre-release preparation for life outside prison and less parole assistance with community reintegration once there (Lynch and Sabol, 2001; Stephen, 2004; Lim *et al.* 2012). They may be released alone and at night which limits immediate access to community-based services such as healthcare and housing (Nelson, Dees and Allen, 1999; Hammet, Roberts and Kennedy 2001; Jarrett, Adeyemi and Huggins, 2006). In addition, prisoners are released to the community (usually the county of sentencing) with little or no money and sometimes without necessary identification needed to access substance abuse treatment, employment opportunities or public assistance (Nelson and Trone, 2000). Their release into the county of sentencing further re-exposes them to high rates of criminal activity, substance abuse and other ex-offenders, thereby increasing their risk of re-offending and returning to prison (Cadora, Swartz and Gordon, 2003).

Whilst healthcare in prison is constitutionally mandated, little effort is made to connect released offenders with community health services (Freudenberg, 2001). Although health problems may be addressed when an individual is in prison, once released into the community these health problems often receive little attention (Solomon *et al.* 2005; Shinkfield and Graffam, 2009). Due to their poor uptake of

care, a large number of released offenders are at increased risk for exacerbation of illness and transmission of infectious disease to those around them (Marlow, 2008). Several studies demonstrate a high risk of death after release from prison (Coffey *et al.* 2004; Hobbs *et al.* 2006; Kariminia *et al.* 2007). Many former prisoners, upon release will experience poverty, violence and/or inadequate nutrition and return to patterns of drug or alcohol abuse upon re-entry (Pollack, Khoshnood and Altice, 1999). In addition, when pre-release coordination between the prison, the parole agency, healthcare services and housing agencies fail, it makes it difficult for released offenders to receive proper treatment for disorders for which they were been treated in prison (Marlow, 2008).

A review of health related issues in prisoner re-entry found that 92% of prisons in the United States provided some discharge planning in the form of referrals to community agencies and programs. However, very few institutions actually made appointments with service providers for those soon-to-be-released inmates (Hammett, Roberts and Kennedy, 2001). Here in the UK, the Care for offenders' continuity of access study which was conducted between 2008 and 2011 asked 200 people in prison or serving community sentences about their healthcare. This study indicated that offenders reported a range of health needs, particularly drug, alcohol and mental health problems. However, although they saw these issues as causing them difficulties, healthcare was not perceived as being important to reducing reoffending. Offenders prioritised other needs and ambitions over healthcare, including employment, accommodation, family and relationships (Byng *et al.* 2012).

It is evident that offenders re-entering their community bring with them significant health problems and a limited understanding of how they can access health services (Jarrett, Adeyemi and Huggins, 2006; Moore, 2007; Marlow, 2008). While there is

profound understanding of the scale of these problems, there is less understanding on the part of research and policy of how to connect these individuals to needed services in the community. Indeed, much of the research on the healthcare needs of released offenders is not evaluative of currently available programs or experimental in exploring which interventions may be the most effective for getting released offenders to access healthcare in the community. Therefore, it is important that research begin to focus further on exploring and understanding what works with regards to linking newly released offenders to healthcare services delivered in the community and whether such care could play a role in increasing released offenders opportunities for successful reintegration.

3.3.9 Political context of offender health in England and Wales

When, in 1947, the National Health Service (NHS) was created to offer universal care, free at the point of delivery, prisoner healthcare services in England and Wales remained internally controlled by Her Majesty's Prison Service (HMPS) and was criticised for being 'invisible' and lacking any external accountability (Smith, 1984). Over time however, criticisms concerning the numbers of suicides in prisons; alleged inappropriate use of psychotropic medication as a disciplinary aid for refractory prisoners; and overall poor standards of care were raised (Ralli, 1994). In addressing these, in 1996, Her Majesty's Inspectorate of Prisons for England and Wales issued a discussion paper entitled 'Patient or prisoner: a new strategy for healthcare in prisons' posing the question: are people in prison with health problems prisoners first or patients and how best to meet their health needs? (Her Majesty's Inspectorate of Prisons for England and Wales, 1996).

This document was strategic to offender health policy in England and Wales as it was the first to advocate that prisoners with a health need be treated as patients and that healthcare for prisoners be provided by the NHS. As a consequence, a joint working group was established between the Prison Services and the NHS Executive to address the issues raised in the document. The report of the working group, the Future Organisation of Prison Healthcare was published in 1999 and endorsed the principle of equivalence of care in offender health acknowledging that historically, healthcare in prisons had been “reactive rather than proactive, over-medicalised and only exceptionally based on systematic health needs assessment” (HMPS/NHS Executive, 1999, P.8). Crucially, the report recommended that prisoners receive equivalent healthcare to that which they would receive in the community, and that this should not be disrupted by coming into prison, being moved between prisons or being released. In addition, the report embraced a public health agenda, acknowledging that good healthcare and health promotion in prisons should help enable individuals to function to their maximum potential on release (Joint Prison Service and National Health Service Executive Working Group, 1999).

With particular reference to prison mental health services, the document; changing the outlook (Department of Health, 2001a) outlined developmental plans to increase the availability of specialist mental health services in prisons, paying particular attention to better meeting the needs of those with severe and enduring mental illness, including considerations for ensuring continuity of care upon release. In 2008, the UK government instructed that all NHS and Department of Health policies apply to the prison services (Department of Health, 2008b). Accordingly, Government policy on offender health evolved over time to focus on pathways of care that could be implemented to enhance healthcare in the prison environment.

This is part of the strategic plan entitled 'Improving Health, Supporting Justice' (Department of Health 2007), which addresses the significant health inequalities of offenders. Towards addressing this inequality, the document Health and Nursing Care in the Criminal Justice System (Royal College of Nursing, 2009) aimed to promote high quality care in the criminal justice system by offering guidance to nursing staff and addressing the specific healthcare needs of offenders.

In 2009, two seminal documents were published by the UK government concerning healthcare services for offenders. The Bradley review into diversion for people with mental health problems and learning disabilities emphasised a need to improve offender health, not least because of the high economic costs to society as a whole resulting from unresolved mental illness, physical ill-health and substance abuse problems commonly experienced by offenders (Bradley, 2009). The Bradley review made wide-reaching recommendations for change, requiring strong partnership between health and justice agencies at both central government and local levels. A framework for the delivery of Bradley's recommendations was set out in Improving Health, Supporting Justice, the Department of Health's offender health strategy which mapped out the direction of travel for the next 10 years (Department of health, 2009). This paper discussed the reality of health service provision for offenders in the context of a constrained financial climate and examined the historically based, and widely held belief in the principle of 'less eligibility' within our society, whereby there is much public and media resistance to allocating resources to improving care for offenders when other, more 'deserving', groups are perceived to be in continuing need (Senior and Shaw, 2011).

Latterly, the drive to improve healthcare services for offenders has widened from the initial focus on prison-based services to encompass those in contact with all parts of

the criminal justice system (Senior and Shaw, 2011). The independent Bradley review made eighty-four recommendations to improve offender health services, ranging from early interventions focussed on young people at risk of offending; ways of safely meeting the urgent mental health, physical and substance abuse needs of those in police custody; strengthening links between prison-based and community services; and identifying the health needs of those under community supervision (Bradley, 2009). Bradley placed particular emphasis on the need for health and criminal justice services to work in partnership, thus acknowledging that the needs of offenders are complex and multi-faceted and cannot be satisfactorily met by one agency working in isolation.

It is important to note that both the 'Bradley review' and 'Improving Health, Supporting Justice' were commissioned by, and published during the lifetime of the previous UK Labour government which was replaced, in May 2010, by a Conservative/Liberal Democrat coalition administration. This coalition government published both a new mental health strategy, No Health without Mental Health (Department of health, 2011) and a Ministry of Justice consultation paper breaking the cycle: effective punishment, rehabilitation and sentencing of offenders (Ministry of Justice, 2010a). No health without mental health reaffirms that offender mental health remains a priority area, along with a continued commitment to Bradley's recommendations of early identification of people with mental health problems followed, where appropriate, by diversion away from the criminal justice system. Breaking the cycle announced a joint Ministry of Justice and Department of Health initiative to pilot and roll out diversion schemes nationally by 2014.

Following on from No Health without Mental Health, in 2012, Her Majesty's Inspectorate of Prisons published the Governments expectations in terms of

healthcare and resettlement (Her Majesty's Inspectorate of Prisons, 2012). With regards to healthcare, the expectations are that prisoners are cared for by a health service that assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. It further maintains that the standard of health service provided must be equivalent to that which prisoners could expect to receive elsewhere in the community and that prisoners with continuing health and social care needs must be prepared and assisted to access services in the community prior to their release. In terms of resettlement, the expectations are that prisoners are prepared for their release back into the community and effectively helped to reduce the likelihood of reoffending, advocating that planning for a prisoner's release or transfer should start on their arrival at the prison. The document maintains that resettlement should underpin the work of the whole prison, supported by strategic partnerships in the community and informed by assessment of prisoner risk and need (Her Majesty's Inspectorate of Prisons, 2012).

Nonetheless, equally longstanding is an apparently widely held antipathy to safeguarding the individual rights of those judged to have abdicated their societal responsibilities through committing crime (Marlow, 2008). While as a group, offenders are clearly vulnerable, using the term 'vulnerable' to describe those who have committed crimes against society may seem contrary to conventional wisdom (Peternelj-Taylor, 2005). Senior and Shaw (2011) argue that the UK media publish exposés almost daily, characterising the criminal justice system as weak on criminals, disrespectful of victims and powerless in the face of perceived 'meddling' from the European Union, commonly illustrated through the UK's legal responsibilities arising from the European Convention on Human Rights. Most topically, the UK government is currently in contravention of a European Human

Rights ruling granting prisoners voting rights; the current Prime Minister, David Cameron, stated in Parliament that: “It makes me physically ill even to contemplate having to give the vote to anyone who is in prison. Frankly, when people commit a crime and go to prison, they should lose their rights, including the right to vote.” (Smith, 2011, p.1)

Thus, debate around the loss of voting rights upon imprisonment reveals the Prime Minister's belief that entry into prison in fact triggers the loss of multiple rights. This illustrates what is arguably the most common theme running through popular media portrayals of UK criminal justice policy; that it is apparently impossible for a society both to protect and uphold victims' rights whilst simultaneously advocating for the enlightened, rehabilitative treatment of offenders (Senior and Shaw, 2011). The media relentlessly perpetuate this dichotomy in preference to examining the potential gains of adopting a public health centred approach to improving access to, and quality of offender health and social care services (Senior and Shaw, 2011). Therefore, this begs the question: to what degree the government is willing to consider the health needs of released offenders as an issue of concern. Moreover, the 2009 offender health strategy, improving health, supporting justice explicitly maintains that there will be little scope, if any, for new resources in the foreseeable future to be channelled towards offender health (Department of Health, 2009). This reinforces the case for maximising opportunities for improvement through better working practices and building on the capacity of the frontline to innovate. Therefore, the drive to utilise the skills, knowledge and expertise of nurses towards improving the health and wellbeing of released offenders in the community is a step in the right direction.

3.10 Conclusion

Imprisonment carries certain psychological costs for prisoners and their families (Haney, 2003b). Retribution demands that prison must be painful; therefore, prison life is constituted through a variety of systematic deprivations designed to punish, coerce, and psychologically intimidate prisoners (Sykes, 1958). Although various forms of imprisonment have evolved over time such as open, closed and dispersal prisons, ultimately, these deprivations contribute to a deep sense of inadequacy and self-stigma on the part of the offender, which inevitably undermines successful reentry. Not only is prison itself a risk factor for emotional distress, the prison population is comprised disproportionately of people from disadvantaged backgrounds with a history of trauma, loss and low resilience to distress (Durcan, 2008). Narratives from offenders are indicative of the self-doubt that haunts them on release and indicates that imprisonment further contributes to a life course trajectory that includes cycles of future imprisonment and poor life outcomes such as economic hardship, poor mental and physical well-being, and low life expectancy (Arditti and Parkman, 2011).

While the literature on offender health abounds with evidence detailing the adverse health and health needs of current offenders, this level of interest does not extend to offenders who have been released from prisons and reside in the community. It appears that once released, it is assumed although incorrectly that these individuals will integrate into mainstream society and will access health and social care services through 'normal' channels. While this may be the case for some offenders, this does not apply to most released offenders. Available evidence indicates that released offenders have different health service use patterns from that of the general population (Awofeso, 2005; Jarrett, Adeyem and Huggins, 2006; Department of

Health, 2007; Marlow, 2008). Yet, there appears to be very little political commitment towards improving the health of these individuals once released from prison which is illustrated by the lack of policy documents addressing their health needs as a unique group in need of tailored support. The focus appears to be towards structurally reintegrating them into society. Even more worrying is the fact that the delivery of health and social care interventions targeted at these individuals in the community is almost non-existent in the UK and mainly provided by non-statutory bodies where they exist. In relation to England and Wales, the National Health Service Commissioning Board is responsible for the healthcare of imprisoned individuals and for everyone else, 'normal' rules apply (Department of Health, 2011). Yet, we know that released offenders are for the lack of a better phrase: 'not normal'.

A sad commentary on our society is that for many, imprisonment represents improved access to healthcare (Jarret *et al.* 2006). Prisoners benefit in healthcare terms from imprisonment and correspondingly, become extremely vulnerable on release. Although we know that the imprisoned becomes vulnerable on release, this review indicates that the health needs of released offenders in the community are under-reported and under-researched. In papers which focused on the health needs of released offenders in the community, such papers due to lack of research, and literature, have relied on extrapolation of prisoner characteristics and informed conjecture of reasons for the poor outcomes in the examination of the post release phase. However, the evidence available indicates that released offenders have problems with accessing mainstream health services, tend to overuse crisis services and enjoy little in the way of preventative healthcare. In addition to their poor health, released offenders experience extreme difficulty in accessing housing, employment and literacy training which are crucial broader determinants of health.

The health needs of these individuals emphasises the need to understand how a range of health services might be offered to this socially excluded group in a way that will promote greater access to healthcare. In support of this, Appleby (2010) argues that improvements in offender health will help bring about broader government aims such as reduced reoffending. Yet, the quantity and quality of evidence which could directly and positively influence actual service delivery models to ensure that they accurately meet the health needs of released offenders in the community is much less advanced. Therefore, this underlies the need for work concentrating on how best to deliver services to this health-compromised group. This also reinforces the need for evidence to inform health and social care provision for offenders released into the community and whether or not nursing is uniquely positioned to develop prevention, intervention, and treatment strategies for offenders released into the community.

4. CHAPTER FOUR – HEARING SILENCES (Silences-Stage 2)

4.1 Introduction

Towards ensuring that an appraisal of this study is made in line with the thinking and decision pathways through which the 'Silences' discussed were located and made explicit, this chapter sets out to identify the 'Silences' at the centre of this research. In doing this, the 'Silences' inherent in my identity as the researcher, the research subject and the nature of research participants will be explored. This chapter will also provide an acknowledgement and a reflexive account of how my world view has impacted on the research. Accordingly, this chapter will commence with the situation of self within the study through an exploration of my identity as a researcher. This will be followed by an identification of the specific issues inherent in the research subject which qualify it as being in need of research and identifying the missing evidence related to the marginalised perspectives of the study participants through an exploration of the Silences inherent in the research participants. Finally, this chapter will conclude by recapping the Silences uncovered with a view to relating how these Silences inform the overall study design.

4.2 Researcher identity

In research, the question of neutrality is counterintuitive and only a greater awareness of one's biases is necessary to situate the researcher within the larger context of a study (Rose, 1985). In order to demonstrate complete grasp of a research study, one must first appreciate the force of what is omitted as a consequence of the researcher's prior experiences, beliefs and present circumstance (Maykut and Morehouse, 1994). In conducting research using The

Silences Framework, it is the listener (ex-offenders in this case) who identifies, conceptualises and ultimately lives with the manifestation of a particular 'silence' in their lives. However, this framework situates the researcher as the main conduit through which 'Silences' are heard, identified and prioritised (Serrant-Green, 2011). This approach to research acknowledges that the researcher is a 'social being' who is influenced by experiences of being socialised into particular beliefs about the world and individuals in it (Hammersley and Gomm, 1997). As a social being therefore, it is important that I situate myself within this study in order to facilitate the appraisal of this piece of work in light of the Silences which were uncovered rather than in spite of them.

I am an unmarried black male of African heritage. My parents both hold degrees at masters level and imbibed in me at an early age 'to do unto others as I would like to be done unto me'. They taught me that as humans, we all bleed red and are all the same. Philosophically, this ethos guides me and forms the bedrock of my values. I believe that it is important to treat people the way I would like to be treated. This means compassion, kindness and a non-judgemental attitude. I believe in the concept of 'second chances' and think that just because an individual broke the law does not mean they are forever incapable of making appropriate decisions or assuming responsibility. I believe that where individuals have committed a crime and imprisonment is considered fit for the crime, then this should be administered. Yet, I believe that people are not 'things' and imprisonment should not be a 'death sentence'.

I feel 'ex-offender' as a label is permanent and based purely on the worst thing that an individual has ever done. I feel that this label is offensive and counterproductive in the context of rehabilitation. I believe that imprisonment should constitute an

opportunity for meaningful rehabilitation which should lead to successful reintegration on release and possibly desistence from crime. However, I feel that the effort of the criminal justice system oriented towards facilitating reintegration is not fit for purpose and is inadequate to the task. I also feel that society as a whole does not consider the health of offenders or those released from prisons a priority and assumes although incorrectly that on release these individuals will integrate normally into society. In this context, it is my belief that imprisonment confers on the individual the status of 'second-class citizen' in the eyes of society.

I have never been incarcerated or held in a police custody suite and have no first-hand knowledge of the experience of imprisonment. Consequently, my knowledge of offenders and the experience of imprisonment are informed by literature. I acknowledge that this lack of first-hand knowledge might be construed as a limitation, but maintain that this does not affect the trustworthiness of this study as my role within this study was to serve as the conduit through which the experiences of the study participants were relayed. As a researcher, I acknowledge that I am inevitably within the network of social relations that I will be analysing and that my interests and goals have influenced my selection of data, choice of methodology, and theoretical underpinning.

In selecting data, I adopted an inclusion criteria specifically designed to identify individuals who I could prospectively follow up in the community for six months. This was a pragmatic choice based on my intent to constructively align my sample with the best possible chance of achieving the objective of this study which is to identify 'touch points' in the community where nursing intervention can be provided. My choice of methodology and accompanying theoretical underpinning are somewhat subjective as fundamentally I chose these because I wanted a structure which would

situate me within the study but in a manner and way which recognised that power within the context of this study lies in the hands of the study participants.

I acknowledge that my role within this study is a somewhat paradoxical one as I am hoping to uncover the meaning system of others and at the same time recognising how my values may be influencing how I make sense of these meanings. However, I have situated myself within this research as an 'outsider' due to my lack of first-hand knowledge on the experience of imprisonment. I increasingly became aware of this status when asked pointedly by research participants about my incarceration history. I answered this by acknowledging that I have never been incarcerated, and could not claim to 'understand' the experience of imprisonment but that it was my hope to learn from their experience in order to gain insight from these. This concern from participants did not unduly impact on the research. On the contrary, it was observed that my honesty and openness in addressing this issue was appreciated and reciprocated in the manner and way the study participants interacted with me which led to the sharing of more meaningful information.

Knowledge is valid when it takes into account the knower's specific position on the issue under examination (Acker, 2000). In uncovering truth through research, the subjectivity of the researcher must be stated and recognised as intimately involved in all facets of the study (Mullen, 1995). While subjectivity encourages a reflection of how the researcher's values impacted on a study, on the other hand, it also encourages a reflection of how it affected objectivity (Ratner, 2002). In carrying out this piece of work, I have endeavoured not to counterpoise subjectivity with objectivity as polar opposites but have endeavoured to compliment one with the other.

Of course, subjectivity can bias the researcher and preclude objectively understanding the lived reality of research participants (Dwyer and Buckle, 2009). However in recognition of this and in being subjective, the recognition of my values has not affected the truth uncovered in this study but has merely helped me situate power with the research participants through the use of The Silences Framework. Moreover, as I had little prior experience of this research area, my subjectivity was constrained in the sense that the agency to enable me to write my 'self' into the study was limited as it did not exist. In being objective, I used a standardised instrument which was administered in person in the same format to all participants to identify cases. My use of this instrument did not negate my subjectivity since it did not render me a passive observer devoid of agency. On the contrary, this instrument and the way it was administered enabled me to comprehend the participants' construction of their own health, thus, situating power with them.

4.3 Research subject

Punishment in the criminal justice system in England and Wales until fairly recently has been focused on the achievement of two principal goals: retribution and deterrence (Hedderman, 2013). This has led to disparities existing between the expectations for ex-offenders upon release and the help they receive on release (Blesset and Pryor, 2013). Moreover, the political discourse associated with crime and imprisonment is hostile and unyielding, often constructed in a manner and way which blames the victim without ever acknowledging the institutional and systemic biases such as substandard education, deprivation, inequities, and the spatial mismatch of health and structural needs which may have led them to prison in the first instance (Blesset and Pryor, 2013). Collectively, the adverse social construction

of ex-offenders through political and public discourse has contributed to the stigma and constraints these individuals face on release (Loury, 2008). As a result, significant barriers exist for ex-offenders as they attempt to navigate limited social networks, the stigma of imprisonment, and returning to crime-ridden neighbourhoods, all of which have been shown to contribute to re-offending on release (Dawes, 2011; Cattell *et al.* 2013; National Audit Office, 2013; Thomas and Hebenton, 2013). Add to this mix, their health needs and this underlies why to do nothing would be counter-productive to society in the long run.

This study is aimed at process mapping the released offender health pathway towards identifying touch points in the community where nurse led interventions can be delivered. The question herein is why research this subject? In the first instance, we know that the health needs of released offenders are significantly greater than those of the general population with a lack of equity existing between need and supply (Butler *et al.* 2004; Williamson, 2006; Bradley, 2009). We also know that ex-offenders re-enter their communities with limited pre-release preparation for the continuity of access to healthcare once outside prison (Byng, Quinn and Sheaf, 2014). Once released, they become hard to reach, do not consider health a priority and use services to address their health and social care needs in a crisis-led way (Awofeso 2005, Department of Health, 2007a).

Therefore, there is a need to improve the continuity in access to healthcare for offenders on release from prison. Amongst others, there is also a cost-benefit case to doing this (Awofeso, 2005). Yet as a society, the health needs of offenders on release into the community is not considered an issue in need of policy intervention. This is evidenced by the fact that currently in England and Wales, no policy exists which recognises ex-offenders as a health excluded group in need of tailored health

intervention (Eshareturi *et al.* 2014). Inevitably, this affects how society views these individuals and concurrently confers on them the status of being marginalised from mainstream political discourse. This state of affairs is further exacerbated by both the cutting back of expenditure on research and increasing restrictions on access to prisons and probation for independent researchers by the ministry of justice (Hedderman, 2013).

Another issue which contributes to the silence inherent in the research subject is societal assumption of the role of criminal supervision. Increased ontological insecurity and higher crime rates have elevated public anxieties about crime and undermined support for penal welfarism in England and Wales (Healey, 2012). This has steered growing pessimism about the effectiveness of the penal welfare model which has led probation officers to supplant rehabilitative goals with an increased emphasis on public protection, risk management, punishment and accountability (Garland, 2001; Cavadino and Dignan, 2006; Healey, 2012). Worryingly, this state of affairs has created a situation in which the interaction between probation officers and their parolees often degenerates into little more than a superficial reporting relationship in which the sort of guidance that one might imagine a probation officer could supply in the context of health becomes impossible to deliver due to a lack of both will and resource to engage in any meaningful intervention (Healey, 2012; Collett, 2013).

While ex-offenders are not a protected class, and this piece of work does not advocate for such a classification, these individuals are disproportionately impacted by their considerable health needs on release from prison (Salke and Fleming, 2012). Protected class demographics refer to groups that have been traditionally discriminated against based on primary characteristics such as race, gender or

ability (Ricucci, 2002; Pynes, 2009). Conversely, vulnerable populations are often identified as groups that are marginalized in some capacity by broader society (Ruof, 2004; Peternej-Taylor, 2005). Marginalisation means the process by which groups find themselves at the edge of society and could be expressed through health, economic or in a political sense (Blessett and Pryor, 2013). The lack of research which explores nurse led provision of healthcare for ex-offenders in England and Wales confers on this subject the status of being marginalised from the perspective of health. This lack of research creates a situation in which the evidence to inform policy and practice is lacking and thus, unwittingly excludes this issue from mainstream policy arena by constructing it as an invisible problem. The cost implication of viewing ex-offenders as a health excluded group may also be an issue fuelling its exclusion from policy discourse. The evidence to prove this is unavailable but in the context of the present economic climate in England and Wales (Hedderman, 2013), it is safe to speculate as to the willingness of policy makers to tackle such a contentious issue in the eye of society.

Moreover, given that ex-offenders are a highly stigmatized group, interventions on their behalf may be viewed as controversial and unnecessary (Thomas and Hebenton, 2013). Despite this sentiment, it is important that the health of ex-offenders be considered within broader discussions of community health. It is recognised that for policy makers, this may not be an easy conversation to have. However, inaction can have detrimental implications for the thousands of ex-offenders released back into society and the communities they return to after imprisonment. Therefore, it is the intent of this study to voice the concerns of this invisible population which has been categorised as such through the inaction of society. Accordingly, in addition to identifying touch points where nurse led

interventions can be delivered to ex-offenders in the community, this study is also a call-to-action to promote a more productive dialogue about ex-offenders through public policy actions which support a tailored approach to the provision of healthcare for ex-offenders in the community.

4.4 Research participants

Imprisonment has grown from a penological intervention applied only to the most violent and persistent offenders to one routinely administered for sometimes arguably minor offences (Conyers, 2013). In restitution for crimes committed, imprisonment constitutes systematic deprivations tailored towards punishing and psychologically intimidating offenders (Arditti and Parkman, 2011). Although being imprisoned could exacerbate psychological trauma, the prison population is overrepresented with individuals from disadvantaged backgrounds who are likely to be from the poorest socio economic group and are similarly poorly educated (Cooke, 2004; Travis, 2005; Brooker and Sirdifield, 2007; Durcan, 2008). As a group, offenders are subject to stigmatization, discrimination, and marginalization; and as such, experience dual, multiple, or overlapping vulnerabilities (Peternelj-Taylor, 2005). Even more worrying is the fact that due to the lack of appropriate pre-release preparation, offenders consider the post-release experience as complex and difficult compared with the prison experience which they consider to be safe and simple (Binswanger *et al.* 2011).

Ex-offenders are not just marginalized they are also a clear example of repeat losers in pluralist politics (Blessett and Pryor, 2013). The Silences inherent in the research participants for this study (ex-offenders) stem from the fact that as a group and despite their health needs on release, they are failed to be identified by policy as

such because they are not considered a suspect class for equal health protection and improvement purposes and therefore do not receive heightened policy attention (Eshareturi *et al.* 2014). Ex-offenders could thus be said not to deserve heightened political protection for a status created by their criminal conduct (Thomas and Heberton, 2013). Having a criminal history continues to mark these individuals for treatment as second-class social, political and economic citizens which profoundly disempowers them beyond their actual sentence (Blesset and Pryor, 2013; Yew, 2013). On release therefore, they lack the means and political legitimacy to enter the legislative arena which limits their ability to advocate in the social and political dialogue about how to deal with their re-entry into society (Thomas and Heberton, 2013).

Furthermore and presently, the role of a probation officer is not specifically designed to ensure that the health needs of offenders are looked into on release from prison (Kemshall and Wood, 2008). Paradoxically and more insidious in its application is the fact that the role of the probation officer has evolved over time from a court social work service to a correctional one firmly entrenched within the penal system (Collett, 2013). Thus, even under a traditional model, society has relied on ex-offenders largely to manage their own reintegration on release. This reliance is greatly misplaced and ignores the reality that the agency to enable ex-offenders truly re-integrate on release is lacking (Burgess-Allen, Langlois and Whittaker, 2006; Farrall, Bottoms and Shapland, 2010). The rub of it all is that these individuals are also silent because they are the most marginalised, poorest and disengaged members of our society (Collett, 2013; Blesset and Pryor, 2013). Reducing reoffending is an important aspiration, but this should not be the only reason for working with ex-

offenders. The evidence indicates that it is unfashionable to argue that we owe them a duty of care, but this does not make it any less true.

4.5 Conclusion

Several Silences lie at the heart of this study and impact the way meaning has been constructed in the search for knowledge. I have situated myself within this study as an outsider due to my lack of first-hand knowledge on the experience of imprisonment. In doing this, I have not counterpoised subjectivity with objectivity as polar opposites but have endeavoured to compliment one with the other while concurrently situating power with the study participants. In recognising the silence inherent in the research subject, this study posits that the political discourse associated with crime, health and imprisonment in England and Wales is often constructed in a manner and way which blames the victim without ever acknowledging the institutional and systemic biases such as substandard education, deprivation, inequities, and the spatial mismatch of both health and structural needs which may have led them to prison in the first place. Consequently, the adverse social construction of ex-offenders through political and public discourse has contributed to the health constraints they face on release.

The Silences inherent in the research participants for this study stem from the fact that as a group and despite their health needs on release, they fail to be identified by policy as such because they are not considered a suitable class for equal health protection and improvement purposes and therefore do not receive equitable policy attention. In addition, the lack of research which explores nurse led provision of healthcare for ex-offenders on release in England and Wales confers on this subject the status of being marginalised from the perspective of health (Eshareturi *et al.*

2014). This lack of research creates a situation in which the evidence to inform policy and practice is lacking and thus unwittingly excludes this issue from mainstream policy arena by constructing it as an invisible problem.

The aforementioned Silences underpin the need for this study and informed the use of TSF as a theoretical guide. However, it is important to note that although these Silences have been presented on three fronts; the researcher, the research subject and research participants, they all exist in a dependent relationship which is dynamic and subject to continually evolve with the conduct of this study. Importantly, the Silences discussed herein also led to the adoption of a case study design for this study. A quantitative instrument was administered in the selection of a fit for purpose sample while qualitative instruments were used to hear participants Silences.

5. CHAPTER FIVE – VOICING SILENCE - Methodology (Silences-Stage 3)

5.1 Introduction

Having already established the theoretical framework underpinning this study and the Silences inherent in the study, it is now necessary to provide an account of the research strategy and the empirical techniques applied. This chapter commences with a recap of the aim of this study which is followed by a discussion of the methodological perspective governing the study. It then moves on to explain the methods adopted and provides an account of how access was negotiated. It further provides a detailed description of the study selection criteria and how participants were recruited. A description of the data collection instruments and how these were administered is also provided. Additionally, this chapter also recounts potential problems which were encountered during the conduct of the research and issues to do with the overall trustworthiness and credibility of the study.

5.2 Study aim and objectives

This study is entitled “Mapping The Offender Health Pathway: Challenges and Opportunities for Support Through Community Nursing”. The study was commissioned by the Burdett Trust for Nursing with ethics approval received from the University Of Wolverhampton School Of Health and Wellbeing Ethics Committee and the Ministry of Justice via the National Offender Management Service. As articulated in the ethics application, the aim of this study was to map the released offender health pathway in order to identify ‘touch points’ in the community where nurse led interventions can be delivered. The study key question is: ‘Where and how

can health interventions be provided by nurses to released offenders now living in the community’?

In answering this question, this study is designed to map the released offender health pathway towards identifying points in the community where nurse led interventions can be delivered in a manner and way which would be ethical, non-stigmatising and agreeable to offenders in the community. This study consequently aligns this overarching aim to the following objectives:

1. To explore and document current levels of support aimed at improving the health of released offenders living in the community.
2. To critically analyse key documentation (policies and procedures, statutory guidance) on the provision of health services for released offenders in the community.
3. To describe and explain the offender health journey on release of the offender from prison into the community.
4. To gather and interpret the views, opinions and lived experiences of released offenders in the context of their uptake of health services in the community.
5. To evidence the opinion of individuals who have been in contact with released offenders with regards to released offender uptake of health services in the community.

It was hoped at initiation that this study would benefit the released offender population as it is oriented towards uncovering health needs from their own perspective and in addition, identifying ways of meeting these needs which are ethical, non-stigmatising and agreeable to them whilst being nurse led in the

community. Furthermore, it was also intentioned for the study to be of benefit to both commissioners and providers of both probationary and health and social care services as it was envisioned that the study would generate evidence to guide and inform service provision for released offenders in the community.

5.3 Methodological perspective

The review of literature conducted in this study indicates that ex-offenders have considerable health needs, become marginalised, fall between care systems and use emergency medical services in a crisis led way on release from prison (Abrace *et al.* 2013; Byng, Quinn and Sheaf, 2014; Eshareturi *et al.* 2014). Furthermore, the Silences at the centre of this study indicate that current dominant discourses around equity of care are contradicted in the provision of health and social care services to ex-offenders in the community. Therefore, this suggests that there is a need for the provision of reliable evidence mapping the health and social care pathway of released offenders towards determining how their needs could be addressed in the community. A study on opportunities to promote health among vulnerable young males established that these individuals benefit from nurse-led health interventions, which improve their overall well-being on release into the community (Wildbore 2004). Similarly, a study looking at nursing care partnership with women leaving jail indicated that nursing is ideally situated to render prevention and treatment interventions for offenders before, during and after imprisonment (Maeve 2003). Consequently, this led to the adoption of the ontological position that the use of nurses in the provision of health and social care interventions to released offenders in the community is a strategy which could increase equity in access to healthcare, reduce reoffending and improve both the health and life chances of these individuals.

In identifying touch points where nursing intervention can be provided, the generation of knowledge concerned with the identification of these touch points was done using a case study approach. Because it was the intent of this research to arrive at reality from the perspective of ex-offenders and to capture the varied feedback offered from the perspective of individuals in their social, health and criminal justice network, epistemologically, this approach was appropriate. Moreover, this methodology enabled research participants to express their thoughts on where these touch points could be located and afforded them the opportunity to voice their concerns on barriers they envisioned could potentially affect the engagement of offenders with such a service. This led to a more meaningful understanding of participants' needs, perceptions, and expectations of where such an intervention could be located. Indeed, this approach is closely aligned with the conduct of applied research as it promotes the investigation of a phenomenon in multiple ways which increases the validity and trustworthiness of a study (Hesse-Biber, 2010).

5.4 Research design

This study employed a case study approach using both qualitative and quantitative methods in collecting data. The research adopted the use of a questionnaire (Appendix IV) as a source of baseline data in providing the general health profile of 26 research participants who met the study inclusion criteria. These individuals were identified through an interrogation of the data held for all offenders on the case load of the Local Delivery Unit by the Performance Information Officer of the Probation Trust. The questionnaires were administered in person by the researcher over the course of four months and were ranked on the basis of poor health with the 10 lowest scoring individuals of either gender (five males and five females) envisioned

to be selected as cases to be followed up prospectively for six months. Although this was the plan at the design phase of the study, on administering and subsequently ranking the questionnaires using the rand scoring tool (Appendix V), only eight individuals self-identified as having a health problem which was corroborated by their low ranked scores - below 50 (Appendix VI). Consequently, these eight individuals were selected as the cases to be followed up prospectively for six months.

The use of the case study approach was adopted because it builds on actual practices and experiences which could be linked to an action (Blaikei, 2009; Yin, 2009). Whilst it is agreed that a case study is a single in-depth investigation into a phenomenon, with the single subject defined as an individual, group, organisation or society (Meiher and Pugh, 1986), there is nonetheless a lack of unanimity as to whether ethnographic approaches should be considered case studies. Several authors consider case study research from only this perspective thus strongly associating case studies with qualitative research (Leninger, 1985; Lincoln and Guba, 1985; Merriam, 1988). However, this position is not supported by Yin (1994) who also proposes a quantitative approach to case studies and posits that these studies could be pluralistic in nature, oriented towards describing, exploring or explaining the issue under investigation. In Yin's context, descriptive case study research describes the phenomenon; exploratory case study research debates the value of further research and suggests various hypothesis or propositions and finally, explanatory case study research seeks to explain various aspects and casual arguments highlighted by descriptive research (Yin, 1994).

Stake on the other hand aligns case study to the ethnographic tradition and provides a categorisation based on the purpose of the study: intrinsic, instrumental and collective case studies (Stake, 1994). Intrinsic case study is oriented towards

developing a greater understanding of a particular case; instrumental case study is aimed at providing information which is of interest in terms of theory building or providing information about other similar cases; collective case study is aimed at investigating a number of cases in an instrumental manner towards providing more extensive information about other similar cases or the provision of an intervention. It is important to acknowledge here that these categories are not mutually exclusive, but on the contrary overlap extensively with only a zone of combined purpose separating them (Stake, 1994).

The case study adopted in this research was a qualitative collective case study as described by Stake (1994). The purpose of this research was to provide a nurse led intervention for ex-offenders in the community informed by qualitatively interviewing eight ex-offenders in an instrumental manner. This approach was appropriate as it oriented the study towards extensively exploring the experience of individual cases in order to determine where and how to provide a nurse led intervention which could potentially facilitate the continuity in access to healthcare for offenders on release from prison.

In addition, available evidence on offender research indicates that the use of this approach permits in-depth analyses of a small sample size (Millward and Senker, 2012). Indeed, this approach has been used in evaluating a reintegration service for long-term dangerous offenders on release (Day *et al.* 2011) and in examining community re-entry experiences of individuals with intellectual disability leaving prisons (Ellem, 2012). On identification of cases, semi-structured interviews were conducted in the first instance (Appendix VII) and exploratory interviews conducted subsequently over the course of the next five months towards identifying touch

points where nurse-led interventions could be provided to ex-offenders in the community.

The themes which emerged from the semi-structured interview of an individual case informed the range of topics which were covered in the first exploratory interview with that case. Thereafter, the themes generated from each exploratory interview informed the issues explored in the next exploratory interview. A semi structured interview informed by the themes which emerged from the exploratory interviews of all cases was conducted with each case on conclusion of their follow up at six months (Appendix VIII). The intent of these interviews was to ensure that the themes which had emerged from following up cases over the course of six months were indeed representative of their views. These interviews at conclusion of follow up led to the emergence of themes which informed the questions asked in the semi-structured interviews of individuals in the social, health and criminal justice network of offenders - collective voices (Appendix IX).

5.5 Research setting

In “Transforming Rehabilitation: A Strategy for Reform” (MOJ, 2013b), the Secretary of State for Justice set out plans to introduce a new system for the management and rehabilitation of offenders in the community across England and Wales. These reforms included the opening up of the market to a diverse range of new rehabilitation providers, incentivised through payment by results to reduce reoffending; a new public sector National Probation Service (NPS) which will be part of the National Offender Management Service (NOMS); the extension of supervision

after release to nearly all offenders leaving custody; and a new “through the prison gate” resettlement service across England and Wales (MOJ, 2013b).

However, at the initiation of this current study in October 2012, the aforementioned reforms had not come into play and the majority of probation services were delivered by 35 Probation Trusts under contract with the National Offender Management Service on behalf of the Secretary of State. At that time, Staffordshire and West Midlands Probation Trust was one of these probation Trusts. Following the implementation of the Transforming Rehabilitation Reform which split the probation service Nationally into Community Rehabilitation Companies and the National Probation Service (MOJ, 2013zz), Staffordshire and West Midlands Probation Trust was consequently split into Staffordshire and West Midlands Community Rehabilitation Company and Staffordshire and West Midlands National Probation Service.

Staffordshire and West Midlands Community Rehabilitation Company was established as a private company in June 2014, and at that time was under the ownership of the Secretary of State on behalf of the Government. On the 1st of February 2015 ownership transferred to the Reducing Reoffending Partnership, a joint venture partnership between Ingeus, St Giles Trust and Community Rehabilitation Initiative under contract to NOMS. The Reducing Reoffending Partnership is also the owner of DLNR CRC (Derbyshire, Leicestershire, Nottinghamshire, and Rutland Community Rehabilitation Company) covering the East Midlands. Within the Reducing Reoffending Partnership, Ingeus is the majority shareholder. The operating remit of the service is to manage the majority of offenders in the community sentenced to Community Orders, Suspended Sentence Orders and those subject to licence conditions or supervision requirements. In

addition, the service is tasked by NOMS to deliver innovative rehabilitative support to offenders. On the other hand, Staffordshire and West Midlands National Probation Service is presently a delivery arm of NOMS and delivers services under a service level agreement. The service is tasked with directly managing offenders who pose a high risk of serious harm to the public (including those whose risk have escalated to high during the course of their sentence) or those released from custody who have committed the most serious offences.

5.6 Sample / Inclusion criteria

The target population of this study were statutory released offenders now living in the community. This population was recruited from a Local Delivery Unit and were accessed via their case officers. This study was introduced to participants by their case officers in the first instance, and subsequently by the researcher to individuals who expressed interest to participate in the study. The inclusion criteria for recruitment were:

- Participants must have been sentenced to between two to eight years in prison and prior to release would have spent between one to four years in prison. These inclusion criteria were informed by the research officer of Staffordshire and West Midlands Probation Trust who advised that these categories of individuals were those who were most likely to have had a licence condition imposed on them which will require maintaining contact with the service for over six months after release.

- Participants could be either male or female and must be above the age of 19.

The age criterion potentially allowed for the inclusion of offenders who were incarcerated at 18 and had spent at least a year in prison.

5.7 Pilot study

The intent of this pilot was to uncover if the questionnaire was fit for the purpose for which it was meant to be used in the study. The pilot was designed to uncover if the questionnaire was user friendly and easily understood, how long it would take to administer, and if indeed, the questionnaire was a reliable measure in the sense that it consistently enabled individuals to self-identify their health status. In addition, the pilot was designed to test for the internal validity of the questionnaire as the researcher wanted to be assured that individuals were correctly self-identifying their health statuses.

Whilst, the administered questionnaire was designed to collate both health and demographic information, the overarching objective of administering the questionnaire was to enable individuals to self-identify their health status towards enabling a ranking on the basis of this self-identified health status. In designing the questionnaire in the first instance, the literature was searched towards identifying certain gaps in knowledge which the researcher felt could be explored in a questionnaire. These led to the generation of questions which were subsequently added to the questions of the general health scale of the RAND 36-Item Short Form Health Survey 1.0a. Questions to collate biographical information were subsequently added in order to enable a comparison of groups to see how responses varied between them.

Once this had been done, a 30 item questionnaire was generated (Appendix X). This questionnaire was then shared with the research officer and probation officers of Staffordshire and West Midlands Probation Trust towards seeking their opinion on the appropriateness of the questionnaire as a data collection instrument to be administered to the individuals meeting the study inclusion criteria. The feedback received from these individuals indicated that several questions sought to enquire about information which the Trust already had and could be shared with the researcher. Following this feedback, questions which enquired about such information were deleted. Please see Appendix IV for the revised questionnaire which was subsequently administered to recruited participants.

Following this, the researcher was put in touch with a volunteer at the Trust who is an ex-offender but was at the time not on license as he had exhausted the terms of his license condition. Subsequently, the researcher introduced himself and the study to this individual and sought his consent to pilot the questionnaire which he willingly provided. The amended questionnaire was then administered to this individual to assess if the wording was clear and appropriate and to assess to what extent the questionnaire could be adjudged to be both reliable and valid. However, prior to administering this questionnaire, the feedback of the research officer of the Trust indicated that the questionnaire should be administered in no more than 20 minutes as participants may not want to be involved if the questionnaire would take more than 20 minutes to be administered. Consequently, at this stage the aim of the pilot also included ensuring that the questionnaire could be administered in less than 20 minutes.

On administering this questionnaire to the aforementioned volunteer in-person, it was observed that the questionnaire took between 10-13 minutes to be administered

and 15-17 minutes if the questionnaire was self-administered. He also fed back on the user-friendliness of the questionnaire in the context of the words used to construct meaning, his thoughts on whether his response to the questions gave a true reflection of his health status, and if indeed the question designed to test for internal validity was fit for its purpose. He indicated that he found the questionnaire straightforward to self-administer as it was easy to understand and that he felt that his ranked score was a true reflection of his health status. He also intimated that the internal validity question was fit for purpose as he indeed had a health condition which explained his low score. The internal validity question simply asked participants if they had a health condition which affected their quality of life (Question 6 on the questionnaire – Appendix IV)

However, he also suggested that not all ex-offenders would have the literacy skills to self-administer the questionnaire as he intimated that several ex-offenders were unable to read and would not like to be placed in a position where they had to admit to this fact. Consequently, he advised that moving forward, the researcher administer the questionnaire in person to all participants and only refrain from doing this where participants ask to self-administer. Consequently, after this test run, the questionnaire was adjudged by the researcher to be fit for the purpose for which it had been designed. In addition, the researcher decided to take on board the suggestion of this individual to administer the questionnaire in-person and only refrain from doing this where participants ask to self-administer.

5.8 Data collection instruments

This study collected data with the aid of a questionnaire which was used to collate the health profile of the study participants and to identify cases. Semi-structured

interview guides were used to situate participants' health journey within the research and to explore the opinion of individuals in the social, health and criminal justice network of offenders. Exploratory interviews were conducted in order to explore the themes which emerged from the semi-structured interviews and every preceding exploratory interview with cases. These exploratory interviews were conducted at monthly intervals after the first semi-structured interview with the participants.

5.8.1 Questionnaire

The questionnaire administered to participants who met the study inclusion criteria and provided consent to participate in the study was close-ended and administered in-person to all cases (Appendix IV). The questionnaire consisted of 20 questions in two sections. The first section explored the health profile of participants while the second section collated demographic details. The first five questions in the health section were obtained directly from the general health scale of the RAND 36-Item Short Form Health Survey (SF-36) 1.0 Questionnaire Items (Appendix XI). On administering the questionnaire, the first five questions were ranked as outlined in the scoring tool for this scale (Appendix V). Participants scoring the lowest were selected as cases to be followed prospectively for six months. The sixth question in the questionnaire asked participants if they had a health condition which affected their quality of life. This question was added in order to assess the internal validity of participants ranking as it was envisioned that all individuals who were ranked as low (50 and below) would have a health condition affecting their quality of life and participants scoring high (50 and above) would not have a health condition.

The 7th to 13th questions asked in the health profile section were designed to enquire on issues which were flagged up by the literature as issues crucial to ex-offender health. This was done in order to provide insight into the general health profile of the individuals meeting the study inclusion criteria and to compare them with the general ex-offending population. Section two of the questionnaire collated demographic information which was obtained in order to cross-tabulate collated data and to enable a comparison of groups to see how responses varied between them.

5.8.2 Semi-structured interview guide for cases on 1st contact

These interviews were conducted on 1st contact with participants after they had been identified as cases from the ranked questionnaires. The interviews were structured in three parts and revolved around participants' health journey (first part), participants' use of services (2nd part) and participants expectations of the future (3rd part). Eight semi-structured interviews were conducted with the eight individuals who qualified as cases from the ranked questionnaires. The interviews were conducted at the premises of the local delivery unit of the Probation Trust. The interviews lasted for no more than 40 minutes. Please see Appendix VII for the semi-structured interview guide.

5.8.3 Exploratory interview

These interviews were conducted only with the individuals who were identified as suitable cases from the ranking of administered questionnaires. The interviews were tailored to explore the issues uncovered during the semi-structured interview conducted on first contact and subsequently after every preceding exploratory

interview. The issues varied with each case and were tailored to explore the presenting issues of individual cases. A total of 24 exploratory interviews were conducted over the course of five months from May to October 2014 (one case had five exploratory interviews, one case had four exploratory interviews, three cases had three exploratory interviews and three cases had two exploratory interviews). These interviews were conducted at the premises of the local delivery unit of the Probation Trust. The interviews lasted for no more than 40 minutes.

5.8.4 Semi-structured interview guide for cases at 6th month

At the end of the follow up of each case at six months, a semi structured interview informed by the themes which emerged from the exploratory interviews of all cases was conducted (Appendix VIII). A total of eight semi structured interviews was conducted. The intent of this interview was to explore the themes which had emerged from the beginning of the study to the sixth month of the follow up of cases. This interview at conclusion of follow up led to the emergence of themes which informed the questions asked in the semi-structured interviews of individuals in the social, health and criminal justice network of offenders - collective voices.

5.8.5 Semi-structured interview guide for collective voices

The semi-structured interviews administered to individuals in the social, health and criminal justice network of offenders (collective voices) were conducted at a location of the participants choice. These interviews lasted for no more than 50 minutes and were informed by the themes uncovered from the analysis of the semi structured interviews conducted with cases at the sixth month point. A total of 21 individuals

who are different to the primary study participants (ex-offenders) made up the collective voices. Their roles were diverse and included probation officers, community nurses, prison healthcare nurses, probation local delivery unit lead, health service commissioners, criminal justice nursing advisor and a prison health inspector. Please see Appendix IX for the semi-structured interview guide of collective voices.

5.9 Logistics of data collection with ex-offenders

All contact with the individuals who met the study inclusion criteria occurred at the premises of Staffordshire and West Midlands Probation Trust. On identification of these individuals, contact was made with their case officers to inform them of this fact and to enquire on if they were still being supervised within the Trust. After this had been done, the researcher and the case officer agreed on a date in which the case officer felt it would be appropriate for the researcher to come in to the Trust to introduce himself and the study to the identified individual. Once the study had been introduced verbally to the individual and an explanation provided of what participation in the research would entail, the researcher then gave the individual a hard copy of the participant information sheet (Appendix XII) and a consent form (Appendix I) to be returned in their next meeting with their case officer if they were happy to engage in the study. Participants were advised that if they chose not to participate in the study, then they should do nothing. In addition, participants were assured that non-participation in the study had no implication to their license condition.

The questionnaires were administered by the researcher in person to participants who had provided consent. These administered questionnaires were thereafter ranked to identify cases. After identifying the individuals who qualified as cases from the ranked questionnaires and prior to the commencement of interviews, the individuals who qualified as cases were informed of this fact by the researcher. Following this, an explanation of the follow up process and the interviews which would be conducted on a monthly basis as part of this process was again given. An explanation of this was initially given by the researcher when the study was originally introduced to all the individuals who met the study inclusion criteria and agreed to participate in the study. Prior to every interview, participants were reminded 24 hours in advance via a text message or phone call of the agreed time and planned duration of the interview. However, not all participants attended at pre-arranged times which necessitated the rescheduling of interviews where they had missed appointments.

5.9.1 Data collection

1. A total of 58 individuals were identified as meeting the study inclusion criteria. Of these individuals, consent to engage with the study was received from 26 of them to whom the study questionnaire was administered. On ranking these questionnaires, 8 individuals were identified as cases (7 males and 1 female). The remaining 32 either declined to engage with the research, had been transferred out of the service, had finished with the service, had been recalled back to prison, were unlawfully at large or were of high risk of causing harm to the researcher as advised by their case officer:

(13 declined)

(8 transferred out of service)

(5 recalled)

(3 finished with service)

(2 missing warrant)

(1 high risk)

2. A total of 26 questionnaires were administered in person to the study participants which led to the identification of 8 cases after ranking;
3. A total of 8 one-to-one semi-structured qualitative interviews were conducted with the individuals who qualified as cases in the first month of follow up;
4. A total of 24 exploratory interviews were conducted with cases from their respective second to fifth month of follow up;
5. A total of 8 one-to-one semi-structured qualitative interviews were conducted with the individuals who qualified as cases in the sixth and final month of follow up;
6. A total of 21 semi-structured interviews with members of the collective voices who are different to the primary study participants (ex-offenders) were conducted at the end of exploratory interview with cases (ex-offenders). The collective voices are individuals who impact on the lived experiences of ex-offenders and include probation officers, community nurses, prison healthcare nurses, probation local delivery unit lead, health service commissioners, criminal justice nursing advisor and prison health inspectors.

5.10 Analysis of data

Data generated from the administered questionnaires were analysed using the scoring tool of the RAND 36-Item Short Form Health Survey 1.0. (Appendix V). Only the General health subscale was used. Internal construct validity was checked with

the aid of a question aimed at checking if indeed the scores generated by the analysis of the questionnaires were corroborated by participants' construction of their own health. Qualitative data generated from both the semi-structured and exploratory interviews were analysed thematically. Whilst NVivo 10 software was used to store and organise data, this software was not used to code data.

Analysing the data thematically was adopted in order to identify and report patterns which it was hoped will shed insight into the points in the community in which nurse led interventions could be delivered to ex-offenders. This approach is supported by Braun and Clarke (2006) who posit that thematic analysis is a method for locating, scrutinizing, and reporting repeated patterns of meaning within data. These analyses were also supported by the use of participants' verbatim quotations which were assigned pseudonyms in order to ensure anonymity. These quotations were used in order to show some of the data from which the results of this study emerged and to give an insight into the experience, meanings and interpretations of the research participants.

Thematic analysis was used to identify the themes which adequately reflected the textual data. Following data familiarisation, data was coded by applying brief verbal descriptions to large chunks of data. At every stage of the analysis, data was altered and modified as ideas developed. Consequently, earlier codings had to be re-adjusted in light of the full picture of the data. Doing this enabled the achievement of a close fit of the coding to the data without having a plethora of idiosyncratic coding. This subsequently generated the themes under which the results of this study were presented. Accordingly, data generated in this study were subjected to qualitative analysis for commonly recurring themes which was done iteratively as advocated by Braun and Clarke (2006):

- 1- Data familiarisation: This entailed transcribing the data, reading and re-reading the data and noting down initial ideas
- 2- Generating initial codes: This entailed coding interesting features of the data in a systematic fashion across the entire data set and collating data relevant to each code
- 3- Searching for themes: This entailed collating codes into potential themes and gathering all data relevant to each potential theme
- 4- Reviewing themes: This entailed re-checking themes and establishing a relationship between themes
- 5- Defining and naming themes: This entailed refining the specifics of each theme and generating clear definitions towards clarifying the overall story of the analysis
- 6- Producing the report: This entailed the selection of vivid compelling extract examples to be used in the presentation of the findings

It is important to note that this analysis was not done sequentially, but on the contrary, it involved alternating between the entire data set, the coded extracts of data and the analysis which was being produced. Consequently, the findings of this study began to be written albeit in a draft form during the analysis stage and not at the end of the analysis. This method of generating study findings fits nicely with the theoretical framework underpinning this study which advocates for the generation of study findings on several levels in a draft form (Serrant-Green, 2011).

Taylor and Ussher (2001) argue that an explanation of themes 'emerging' or 'being discovered' is a passive account of the process of analysis which contradicts the dynamic role the researcher plays in identifying these themes and selecting which are of interest. In this sense, themes reside in the interrogation of the data and the

creation of links as understood by the researcher not merely in the examination of the data at a superficial level (Ely *et al.* 1997). Therefore, towards providing an aid aimed at evaluating the trustworthiness of the analysis conducted herein, it is important that I make explicit the assumption which informed my use of this method of analysis.

My use of this method of analysis was informed by the fact that as a method, thematic analysis is compatible with both constructionist and essentialist paradigms and is not underpinned by any theoretical framework (Braun and Clarke, 2006). Indeed, it could be a realist or essentialist method which is aimed at reporting the reality and experiences of study participants or a constructionist method aimed at uncovering the social construction of meaning (Braun and Clarke, 2006). This attribute of qualitative thematic analysis fits nicely at a theoretical level with this study which is situated in an anti-essentialist paradigm. Consequently, the flexibility afforded by this method of analysis ensured that at a theoretical level, the method did not contradict the theoretical ethos underpinning this study.

However at a practical level, what is important is that the method of analysis aligns with the research question (Wertz *et al.* 2011). Thematic discourse analysis, thematic decomposition analysis, interpretative phenomenological analysis (IPA) and grounded theory were discarded as potential methods of analysis for the following reasons: Thematic discourse analysis is fundamentally used to explore how language is used to construct meaning (Roberts and Sarangi, 2005) while thematic decomposition analysis explores the social meaning of the language used by research participants and is ideally suited for research oriented towards exploring the role of social influences on a specific issue (Ussher and Mooney-Somers, 2000). On the other hand, both IPA and grounded theory seek patterns in the data with IPA

oriented towards understanding individual experience of reality in great detail so as to gain an understanding of the phenomenon in question (Smith and Osborn, 2003; Holloway and Todres, 2003) while grounded theory is aimed at generating a plausible and useful theory of the phenomena that is grounded in the data (McLeod, 2001).

The aforementioned methods of analysis all aim to uncover themes across entire data sets rather than within single data items and in this sense interface with qualitative thematic analysis (Braun and Clarke, 2006). However, they were all explored and found not to align with the intent of this study which was to identify touch points in the community where nurse led interventions could be provided to ex-offenders. Consequently, this study adopted a qualitative thematic analysis as this method of analysis is not prescriptive on the nature of research it could be employed in (Hayes, 1997). On the contrary, qualitative thematic analysis offers the flexibility to be used as an instrument of analysis in research underpinned by various theoretical perspectives on the one hand (Wood, Giles and Percy, 2009), and on the other hand, offers the flexibility in determining themes in a number of ways while concurrently maintaining consistency (Braun and Clarke, 2006).

Consequently the themes uncovered in this study were arrived at in an inductive or bottom up way (Frith and Gleeson, 2004). In this sense, the themes which emerged were not informed by an attempt to fit them into my analytic preconceptions as a researcher or any pre-existing coding frame, but emerged as a consequence of the interrogation with available data (Patton, 1990). This inductive qualitative thematic approach is in direct opposition to the theoretical qualitative thematic approach which is informed by the researcher's theoretical or analytic interest in the research area, and is thus more explicitly analyst-driven (Braun and Clarke, 2006).

As this research was aimed at the identification of touch points in the community from the narrative of ex-offenders where nurse led intervention could be delivered, I felt that the inductive qualitative thematic analysis method was appropriate as this method is suited to the location of these points from the narrative and 'only the narrative' of the study participants. In addition, this method of analysis was chosen in order to enable me to provide a rich thematic description of my entire data set towards facilitating an assessment of the trustworthiness of the analysis in light of the predominant themes which emerged from my interrogation of the data. Furthermore, in the context of logistics, this method of analysis was chosen because it does not require the same level of detailed transcription required in conversation, discourse or even narrative analysis (Wood, Giles and Percy, 2009). It was important that this criterion be considered as I had a limited amount of time to conduct semi-structured interviews, transcribe them and subsequently generate themes to be explored in the exploratory interview all in under a month for 8 cases consistently for six months.

Finally, I acknowledge that this research is not devoid of my theoretical and epistemological commitment and that the analysis conducted herein has not been done in an epistemological vacuum. Therefore, it is possible that these may have unwittingly influenced my analysis of the data at a sub-conscious level. In this regard and towards ensuring that this does not have an untoward effect on the trustworthiness of the analysis conducted herein, these commitments have been clearly conveyed in the preceding chapters where I have endeavoured to discuss the theoretical framework which underpin this study (Chapter Two) and the Silences and biases at the centre of this piece of work (Chapter Four).

5.11 Timeframe

The pilot phase for the testing of the questionnaire commenced in March 2013 and was completed in April 2013. Thereafter, ethics application was submitted to the University of Wolverhampton School of Health and Wellbeing ethics committee in May 2013 with approval to commence the study being received on the 13th of June 2013. Following this approval, ethics application was made to the Ministry of Justice via the National Offender Management Service on the 19th of June 2013 with approval received from the National Offender Management Service on behalf of the Ministry of Justice on the 9th of July 2013 with the proviso that final approval to commence the study be given by the local probation Trust (Staffordshire and West midlands Probation Trust). Both applications were subsequently considered locally at the probation Trust with local permission received to commence the study on the 8th of October 2013 in a meeting with both the research officer of the Trust and the head of the Local Delivery Unit.

Following this meeting, a subsequent meeting was arranged between the researcher and the performance information officer of the Trust towards setting out the mechanics for the identification of the sample which met the study inclusion criteria. This meeting was held on the 29th of October 2013 in which it was agreed that a data query be run in November 2013 and January 2014 towards identifying the sample meeting the study inclusion criteria. Consequently, on the 18th of November 2013, the researcher received a list of 42 individuals who met the study inclusion criteria and on the 6th February 2014, a further 16 individuals were identified to have joined the service from the date of the last run which consequently brought the total number of individuals identified to have met the study inclusion criteria to 58.

Contact with the individuals who met the study inclusion criteria commenced on the 1st of December 2013 towards introducing the study and seeking for informed consent. Following this and only after receiving informed consent, questionnaire administration commenced on the 13th of January 2014 and ended on the 14th of May 2014. Cases were identified from the ranking of the questionnaires on an ongoing basis. The follow up of cases commenced in May 2014 and ended in December 2014. Cases were followed up for only six months and the end date of December resulted as a consequence of the first interview of the last case recruited into the study being conducted in June 2014. The interviews of individuals in the collective voices were held between December 2014 and February 2015.

5.12 Ethical considerations

The design and conduct of this study was fully approved and monitored in accordance with the guidelines provided by The University of Wolverhampton School of Health and Wellbeing Ethics Committee. This study was also underpinned by the University of Wolverhampton's Equal Opportunities policy and in line with the Data Protection Act 1998. The working practices and confidentiality requirements of all participating individuals was fully respected and the anonymity of all participants in the research was assured.

Confidentiality was maintained by not divulging information to individuals external to the study except for those directly involved in the study, such as research supervisors. Even when information was divulged to research supervisors, they were unable to link the data to participants, as data was anonymised by using codes on the questionnaires and interview transcripts. Any quotes used in the research used a

pseudonym rather than the participants' name. Data was also protected by keeping questionnaires, transcripts and audio recording in a secure facility at the University of Wolverhampton. External hard drives and USB devices were password protected. Audio recordings and transcripts were stored in a secure and separate place from consent forms and personal information.

Approaches to participants were made in a permanent form which offered an explanation of the purpose of the study and how the results will be used, an undertaking of anonymity and an assurance of the opportunity to withdraw at any time. Consent was sought in writing and permission was also sought from participants to use extracts from their data in the final thesis and in any academic publication. It is possible that individual participants may-be able to recognise their own information; however, as far as possible, this information was anonymised.

Participants were told that if they disclosed a crime or potentially dangerous thoughts which could cause harm to self or others, this would be immediately reported to their case officers and the research officer of Staffordshire and West Midlands Probation Trust for appropriate action in line with Trust policy. In addition, the researcher was aware that the setting of the research was one in which participants could be easily coerced by their case officer to engage in the study. Accordingly, it was the researcher's position to exclude immediately from the study any participant who declared that they had been coerced to participate in the study.

It was not envisaged that this study would cause harm to participants. Nonetheless, it was originally planned that where it was uncovered that this had occurred, such individuals would be immediately excluded from the study and offered appropriate help from the range of services provided by Staffordshire and West Midlands

Probation Trust. Towards ensuring that the relevant ethical approval was obtained before commencing this study, in addition to seeking approval from the University of Wolverhampton School of Health and Wellbeing Ethics Committee, ethical approval was also sought from the Ministry of Justice via the National Offender Management Service and the local delivery unit.

5.13 Potential problems

Please see Appendix XIII for the risk analysis of this research which was a standard template for potential risk envisaged at the beginning of this study. At the point when this study was envisaged, it was presumed that this analysis would be a guide to be built upon. However, during the conduct of this research, only one problem was encountered which was not envisaged at the beginning of the study and consequently was not planned for. This problem was the restructuring of the probation service. The probation service was restructured during the data collection phase of this study and entailed the transfer of low risk offenders to privately run companies known as community rehabilitation companies and placing the management of high risk offenders within the scaled down probation service known as the public protection service. These changes affected the morale of staff within the service as they appeared to be overwhelmingly against this restructuring which was conveyed to the researcher through several informal discussions. In addition, the drive to privatise the service led to uncertainties among members of staff about the security of their jobs and the nature of supervision which they may be required to carry out in the new service.

This impacted on the research as probation officers became increasingly worried on how this restructuring might impact on the security of their jobs, and consequently, became less engaged with the study with regards to furnishing the researcher with information on when study participants were scheduled to be supervised at the Trust.

5.14 Research rigour

Rigorous (trustworthy) research is one which applies the appropriate research tools to meet the stated objectives of the investigation (Mays and Pope, 1995). However, evidencing rigour in qualitative research involves demonstrating that a research is credible, transferable, dependable and confirmable (Lincoln and Guba, 1985). This section is an account of how trustworthiness was demonstrated within this study adopting the framework on rigour by Lincoln and Guba (1985).

5.14.1 Credibility

This measure of rigour refers to the confidence which can be had in the 'truth' of the findings (Patton, 2001). Lincoln and Guba (1985) posit that this measure can be evidenced by establishing prolonged engagement between the researcher and the participants; establishing that triangulation was used and that member checking was done. This study thus evidences credibility as follows:

1. Prolonged engagement - Prior to the commencement of the collection of data, I spent approximately twelve months interacting and developing rapport and trust with participants. This facilitated understanding and co-construction of meaning between myself and the participants which enabled me build trust,

rise above my own misconceptions and become oriented to the situation in which healthcare is accessed in the community on release from prison. Consequently, this prolonged engagement enabled me appreciate the context of the narrative conveyed during the data collection phase of the study.

2. Triangulation - The use of multiple data sources was adopted to inform the findings of this study. The findings of this study were informed by ex-offenders (silent voices) as one data source and individuals in the collective network of ex-offenders (collective voices) as a second data source. Whilst the narratives of the collective voices were used to corroborate the findings of the silence dialogue, these narratives were also used in alignment with the criticalist approach to contextualise silent voices narratives to the realities within the health economy.
3. Member checking - My interpretation of the narratives of the silent voices were checked in the silence dialogue by the study participants. This ensured that the voices of the study participants were not further silenced, and concurrently facilitated the intent to ensure that my practice did not unwittingly mitigate against uncovering the Silences heard by the study participants. This gave participants the opportunity to correct errors, challenge what they perceived as wrong interpretations and importantly, availed them with the opportunity to assess the preliminary study results.

5.14.2 Transferability

This measure of rigour through the provision of a 'thick description' revolves around demonstrating that the outcomes of a research can be applied in other contexts

(Lincoln and Guba, 1985). Accordingly, this refers to describing a study in sufficient detail in order to facilitate the evaluation of the extent to which the conclusions drawn are transferable to other times, settings, situations, and people (Denzin, 2001). In alignment with this ethos, this study clearly described: the need for the research, the context in which healthcare is situated politically and personally for released offenders, the study inclusion criteria, the set of methodological instruments applied in investigating the research question, the method of analysis and the theoretical underpinning of the study. All the aforementioned were clearly conveyed towards ensuring that sufficient detail was provided in order to enable an independent evaluation of the extent to which the conclusions arrived at could be transferred to other settings.

5.14.3 Dependability

This measure of rigour relates to showing that the findings of a study are consistent and could be repeated (Miles and Huberman, 1994). The technique for establishing this measure of rigour is the external audit (Lincoln and Guba, 1985). External audit thus entails having a researcher not involved in the research process examine both the process and product of the research towards evaluating whether or not the findings, interpretations and conclusions are supported by the data (Lincoln and Guba, 1985). The ethos of external audit was applied to this study through the research supervision received. The research was conducted solely by me with the supervision received oriented towards ensuring that the study outcomes were consistent and could be repeated. The supervision achieved this by ensuring that there was consistency in the standard by which the research was conducted, data was analysed and findings were presented while concurrently conveying in precise

language what was being done at every stage in the research process. Consequently, this supervision was aligned with ensuring that each process of the study was reported in detail to enable a potential external researcher to repeat the study and achieve similar results.

5.14.4 Confirmability

This measure of rigour relates to the extent to which the findings of a study are shaped by the study participants and not researcher bias, motivation, or interest (Lincoln and Guba, 1985). This study demonstrated confirmability through the use of external audit as applied in the supervision received, through the adoption of member checking which ensured that my interpretation of the narratives of the silent voices were checked in the silence dialogue by the study participants and in being reflexive by acknowledging my biases and preconceptions in the section on researcher identity (4.2). By adopting all the aforementioned, this study ensured that the outcomes of the study were informed by the study participants and not the biases inherent in my position as the researcher.

6. CHAPTER SIX – VOICING SILENCE - Analysis (Silences-Stage 3)

This chapter presents the results which emerged from the first three phases of analysis. As a consequence of applying TSF to offender health research, the presentation of findings contained herein is done in an anti-essentialist tradition. These findings directly evidence the reality of participants and presents facts from their perspectives as a consequence of their position in the social world at the particular point in time this study was conducted. Taking cognisance of the fact that experience is at once an interpretation but also in need of explanation (Scott, 1991); Chapter Seven adopts a criticalist approach in exploring the findings presented herein. A sample script is provided in the appendix illustrating how analysis was conducted (Appendix XIV).

6.1 Phase 1 – Researcher review

Phase 1 began with analysis of the data collected by the researcher with reference to the research question: Where and how can health interventions be provided by nurses to released offenders now living in the community? This phase is referred to as 'researcher review' and comprised of the semi structured interview conducted with participants in the first month of contact and the exploratory interviews which were conducted with participants from the second to the fifth month of contact. At the end of this phase, the initial findings from the analyses of these interviews led to the generation of the study initial findings. These initial findings informed the semi structured interview questions which were discussed with participants at the sixth month (Appendix VIII).

6.2 Phase 2 – Silence dialogue

At the conclusion of phase 1 of the analysis and the production of the study's initial findings, analysis moved on to Phase 2 which entailed a review by the participants (listeners) of the initial findings provided in Phase 1 by the study researcher. Listeners are the ex-offenders who met the study inclusion criteria and qualified as cases. This phase entailed the semi structured interview conducted with participants at six months. This phase of analysis is referred to as the 'silence dialogue' primarily due to the fact that it was intended to ensure that the voices of the researched group were not further silenced, and the intent of the researcher to ensure that the researcher's practice did not unwittingly mitigate against uncovering the Silences heard by the study listeners.

This section will present the views of ex-offenders organised using a travelling model of progression. Findings are presented under three subheadings; the experiences of participants before release, on release and after release. In addition, findings will also be presented on the views of participants on a nurse led service, factors which they posit can contribute to the continuity in access to healthcare for offenders in the community, and the 'Silences' which were uncovered as a consequence of conducting this dialogue with ex-offenders.

The participants referred to here are all custodial based ex-offenders and the intent of this dialogue is to ensure that the themes which emerged from the follow-up of these individuals in the preceding six months are reflective and representative of their views. This acts to ratify, refute, challenge or further contextualise the findings from the study towards coming to terms with the impact, importance and potential realities for the offenders.

6.2.1 Before release

This phase of the analysis explores the pre-release experience of offenders while in prison towards uncovering the nature of support they received and the consequence of received support on their ability to access health services on release.

Although participants maintained that they had no pre-release support oriented towards enabling them to access healthcare on release, it was clear that participants felt that they were properly treated for their health condition while they were in prison:

They had me on Warfarin for my whole sentence. And I were better in prison than I were in the community, if I'm being honest, because they monitored me more. Every three to four days I've been monitored in prison. Especially in the bigger prisons, because it's quicker for them. So, mind you they were quite good in prison if I'm being honest.

SP, Male, 27

Because before I went into jail I told them, "I'm on this, I'm on that, I'm on that. I've got ulcers and that, blah blah blahs." And then they said, "Have you got a doctor and that?" And I says, "Yeah." And I gave them the details and that and they got in touch and that's when they put me on the medication.

AR, Male, 28

On the support they received from their respective offender supervisors in prison towards preparing them for release, participants were unanimous in maintaining that

they had no pre-release support from their offender supervisors with regards to health while they were in prison. Indicative comments include:

I know you've got inside probation in prison, they're a waste of time. I think probation on the outside should interact more with their person inside a couple of months before they're due out, they should get that report together.

BR, Female, 59

My Offender Manager in prison was terrible for my whole sentence. They didn't do anything for me. I didn't even bother with my Offender Manager to be honest, they weren't very good at all in prison. The probation officer is much better so I just went straight to xxxxx I did, my probation officer. And if I had a problem she'd sort it out for me. So my Offender Manager wasn't very good at all I don't think in prison.

SP, Male, 27

The aforementioned findings indicates that it is the position of participants in the silence dialogue that the nature of received pre-release health support did not adequately empower offenders to be able to access health services effectively on release from prison.

6.2.2 On release

This phase of the analysis explores the on-release experience of offenders towards uncovering what on-release support they received for their health needs and how this impacted on their ability to seek help in the community.

When participants were asked what on-release support they had in prison to prepare them for accessing health services in the community, they overwhelmingly maintained that they had no such support with regards to health:

Between open prison and coming out? No. And I had high blood pressure, respiratory problems, asthma and stuff like that and Mirtazapine for depression. And it is was like "Have you got enough meds for the next 30 days?" It wasn't "Where are you staying? Here's the number for a local GP" or anything like that.

CC, Male, 44

They knew I was being released but they never even gave me a prescription to go and get extra inhalers before I could make an appointment with the doctor and I was without inhalers for two days. But there was nothing from the prison, no prescription to take to the doctor or Healthcare Centre. No letter to give to the doctor to say what medication you'd been on, whether you'd had your hepatitis A, B or C, or 1,2, or 3. None of that.

BR, Female, 59

Interestingly and in response to the aforementioned question, where participants cited any support, they did this in the context of their day release. They cited their prior day release as the support they received in preparing them for accessing health services post prison:

What they were providing for me is that I should come out and spend about three days or something like that. The first would be three days and then the next would be seven days but I never get that.

LM, Male, 80

Coming out of the prison every weekend, once, twice a month. Then it got to every week and then I started working outside. You just adapt to it.

SK, Male, 45

Furthermore, there appeared to be a range of experiences with regards to offender's pre-release preparation for access to a GP on release. While some participants indicated that on release they were asked by staff in prison if they had a GP, other participants indicated that this was not the case:

No. Not in the prisons no. Not for me. A lot of people came out without medication and they were told just to go to find a doctor or go to the hospital if need be.

BR, Female, 59

They didn't give me anything at all. They gave me my drugs I needed to last me a few weeks and then it was left to me to go to my GP off my own back.

SP, Male, 27

However, even when this issue was raised by a participant prior to being released from prison, this participant maintained that the responses of prison personnel were not helpful:

No I was never asked that. And then I told them "I haven't got a GP to come out to in the area that I was moving to and could I have a prescription for medication?" and they said "No".

BR, Female, 59

Yet, what was clear was that participants were asked if they had a GP by staff in prison in cases where it was considered that an individual had a serious health condition:

Yeah I got asked "Do you have a GP out there", I said "Yes". Because I'm on regular medication so they needed the details of my GP so they could refer the information.

SK, Male, 45

Yeah and I signed paperwork too, to let the prison doctors and nurses phone my GP and to tell him that "Yeah he has to carry on with this, he's on this, he's on that. He's on his inhalers so I want him to carry on when he gets out"

AR, Male, 28

It was also uncovered that even after some participants had found a GP in the community, their medical records were delayed in getting to the GP which consequently impacted on the GP's ability to issue repeat prescriptions:

The GP I signed up with was waiting for the prison to send my medical records back. Instead of giving them to me when I left in an envelope to give to my GP. And it was an eye opener put it that way. They gave me

tablets to come out with but the main ones I needed was my depression ones and my painkillers, they just put them in an envelope with no name on them or nothing. And the GPs wouldn't recognise that as a proper medication. So I was stumped.

DH, Male, 52

And I think there should be some sort of follow-on because they didn't seem to know anything about my health history, about my blood pressure and things like that from when I've been in prison which is stupid really. I then had to re-discuss it with them because they didn't have any of my history.

CC, Male, 44

The aforementioned findings indicates that it is the position of participants in the silence dialogue that there is a lack of on release health support oriented towards enabling offenders to access health services effectively on release from prison.

6.2.3 Post release

This phase of the analysis explores participants' construction of the issues supporting and mitigating against their ability to seek health help in the community.

Participants were unanimous in maintaining that family support was crucial and helpful in facilitating their structural re-integration back into society on the one hand, and on the other hand, in helping to access health services post release:

My son's helped me go to the doctors and that, sometimes I couldn't walk. They'd take me in the car. They were there to make sure I had medication regular at the right times. And my missus was there to make sure that I was eating well, eating on time. You just get a lot of support from each other, we're very close. You get relatives coming around asking 'How are you?' and people, you get a lot of support, moral and physical support from both sides.

SK, Male, 45

Because when I came out I was how can I put it? Scared stiff. My son picked me up, I saw him in the car park and I just ran straight for him. Came out and we went to McDonalds, he said "I'll be back in a minute dad" I was just stood there froze, I didn't know what to do. It's weird but he got me through everything my son has. My right hand man he is.

DH, Male, 52

Furthermore, participants maintained that family support was crucial to avoiding re-offending and that the fear of disappointing one's family was key to the process of reintegrating back into society:

I want to do it for my family. At the end of the day, my family comes first. I don't want to be in a box.

AR, Male, 28

I wouldn't be here. Yeah because quite a few times I've had the family to talk to me to calm me down because with my panic attacks and that and

my depression and they do calm me down a lot. Just by hearing their voice and it's weird how it happens. But they've been good with me but if I ain't got them I wouldn't be here.

DH, Male, 52

Although family support was found to be crucial, it was uncovered that not all offenders had this support. Participants maintained that although family is irreplaceable, the support received from family members could be achieved through the supervision received if this was personalised and commenced before the offender left prison:

You need to liaise with them before they come out to make sure that they understand that you're not there to lock them back up. I mean obviously if they do something that's different but you're there-- but you can't replace somebody's family there's no way of replacing somebody's family but you can put some sure footings down for them and say "Look before you do that, come and see me. Before you start thinking like that come and see me, I won't tell you what to think but just come and see me"

NH, Male, 49

However, whilst it was uncovered that all the participants interviewed were currently accessing health services for their presenting health problems, a common theme which underpinned their interaction with medical personnel in the community was the timeliness of received services:

Well I think having to wait three days for an appointment is bad at the doctors, even to see a nurse. I do think that's pretty bad. And I think there should be something there available. I think they should have extra nurses

on to cope with people that need to see a doctor that day, to go in and see a nurse.

BR, Female, 59

The bad ones is you have to wait for appointments and nobody sees you, the doctors when you have to make an appointments, sometimes you can't get an appointment, they don't understand that I'm in such pain I need one ASAP. Then you have to wait. That's no good when someone's in really bad pain and they're on the phone, they don't understand.

SK, Male, 45

In addition, it was uncovered that participants did not construct or qualify the supervision received in the context of health. However, participants were unanimous in maintaining that their supervision by the probation service has been hugely beneficial to them. The following comments are indicative of this:

I had a very good probation Officer when I came out. I could talk to her about anything and I had to do everything myself, the prison did nothing for me, I had to find my own accommodation and XXX was a good help there.

BR, Female, 59

It is a good thing probation is and in a way you know every time I've been on probation I've been okay. It isn't until probation is finished and there's no backstop anymore that I've got into trouble. I wouldn't tell them that but in a way it does me as a person good to have the backstop, the reminder.

Because if there's no check measure then I can fall off the boat you know what I mean?

NH, Male, 49

Following the aforementioned comment, this participant was asked how he was positioning himself towards ensuring that following his disengagement from the service he does not reoffend:

I'm moving. Yeah I'm going to move.

NH, Male, 49

It is important to note that this intent to move had emerged in the context of reoffending. Indeed other participants in response to issues which they considered could help them avoid reoffending maintained that moving from their present location was crucial:

Because I've got nobody around me. The people don't know where I am and they can't knock on my door for me or nothing if you know what I mean?

AR, Male, 28

And I think it's one of those hard things isn't it because there's some people coming out and they haven't got-- or they have got a group of friends and getting released to an area and the group of friends are trouble.

CC, Male, 44

In addition to relocating, being employed was cited as crucial to avoiding re-offending on release:

I was coping with things and started working and the work stopped me from being bored which occupied my brain which I've said before and I've started to deal with it alright.

CC, Male, 44

A good job. And I go to the gym instead of going out and getting drunk and taking drugs all the time. I don't do that no more. I go to the gym. I go to work.

SP, Male, 27

6.2.4 Silence dialogue: nurse led service

This phase of the analysis evidences the views of the silence voices on how they would like to see a nurse led service delivered and the potential impact such a service could have on their health and wellbeing in the community.

While it was uncovered that some participants had the agency to navigate and access health services post release without help, it was clear that irrespective of this, all the participants who engaged in this study indicated that they would need help in navigating the health system. They maintained that a nurse led service could help them navigate and access health services post release from prison if such a service was easily accessible:

As I've stated before, everybody coming out of prison on licence have to come to the probation Office, and perhaps they could have an office set up for a nurse so they can register with a doctor because in prison the facility is not there. And some offenders might go to a different area so

they've got no doctor, no nurse. So if there was a facility in the probation Service they would then be able to locate the doctor, a nurse, a dentist, something like that.

BR, Female, 59

Because when you come out of prison you have to see your probation Officer that day and because the prison do not help you find a doctor, having an office in probation centres, that's a good step forward, to finding a GP or accessing like your medical records from your past or your National Health number, I think that would be good.

BR, Female, 59

Importantly, it was also posited that such a service could help bridge the health re-entry gap:

on your initial appointment when you leave prison the day after you come to probation you could maybe have someone there or just a little office somewhere where you could see a doctor or a nurse or something and then get them to give you a follow up appointment in a weeks' time or something so you can start the ball rolling straight away.

SP, Male, 27

With regards to the ideal location for the provision of such a service and where they felt health information could be provided on release, participants were unanimous in their agreement that the probation service would be ideal for the location of such a service:

Near to the probation service because everybody knows where the probation service is, where they've got to go. Or if they do a late night probation it could be linked to the late night.

BR, Female, 59

Somewhere like here really. It's got to be something quite local, I would say from my standpoint it's what you're comfortable with. Because you've been here once it's marginally comfortable than going to new places. I mean work I am used to it but when I first came out I was a bit weary of anywhere really.

CC, Male, 44

When participants were asked how they would prefer a nurse led service to be provided, they maintained that they would like such a service to be run as an appointment service or a drop in centre. In support of a drop in centre participants comments were influenced by the nature of their 'struggles' on release:

For offenders, I think a drop-in. I think a drop-in because they're going to make an appointment and they ain't going to come. Because a lot of people coming out of prison are just living day to day aren't they? And they're just waiting to go back to be honest, aren't they? Well half the people that come out of prison I'd say end up back in there don't they? Within a few months. So a drop-in centre will definitely be best I think.

SP, Male, 27

People from prison aren't good with appointments, I'll tell you that now because I'm not very good. This is the only appointment I always keep and the only reason I keep this appointment is because I'll go back to prison. The amount of times I've made an appointment with the doctors and I've let them down because there's always something more important. Whereas there's nothing more important than your liberty and XXX has got that over me.

NH, Male, 49

In support of an appointment service, the following comments were made:

I would prefer the appointment. Because at times with the drop-in centre you can't get to what you want to do but when you get an appointment that's a different thing altogether because the person that's appointed you is looking forward to you. So it's much better than a drop-in centre because a drop-in centre can become like Age Concern. Though you make the appointment a lot of people who go there just come in and it's better to get service straight away with the appointment already. So I think the appointment is more important.

LM, Male, 80

But if they have a drop-in centre then they've all got to wait in line haven't they? To see that particular nurse or nurses. That might get a little bit aggravating especially if they've just come out of prison and they've got to wait in a queue because it's like that in prison you see, they have to wait.

Queue up for the meds and they have to wait and so that could still affect them mentally.

BR, Female, 59

It was clear that this participant opted for an appointment service as this individual felt that the manner and way a drop in centre may operate might be off putting as it could potentially mirror the experience of imprisonment which may be psychologically taxing for ex-offenders now residing in the community. Nonetheless, participants were unanimous in maintaining that any provided service must endeavour to operate on an advisory basis as a 'sign-posting service:

Some sort of advisory at probation because a lot of the time you don't know whether to go to the doctors, go to the hospital or just sit it out and hope it gets better do you? Do you understand what I mean? And that's where a lot of the issues are.

NH, Male, 49

You can directly tell the nurse what your problems are and she can give you whatever medication she's allowed to give you or she could give you advice on what to do next. Like a Citizen's Advice Bureau regarding health issues. Give a lot of support to the person and other alternatives regarding going to the hospital and having an operation, because you can get advice on doing other things like alternative.

SK, Male, 45

However, a participant expressed concern into the need for such a service arguing that various health services exist in the community which ex-offenders could use on release from prison:

Have you got enough doctors or nurses that are available for this kind of job or have you looked at any time that some doctors could give voluntary, look into this because first everybody needs to go to the doctors or the hospital.

SK, Male, 45

When participants were asked how they proposed a nurse led service to work with regards to data protection, they presented contrasting views with some in favour of a confidential service and others in favour of a non-confidential service. In support of a confidential service the following comments were made:

They should sign a contract saying that whatever we discuss stays between us and no third parties should know about it. Then leave it at that? Because there are a lot of people out there that don't want to talk about their business to nobody. Once a probation officer gets to know your problems or if it's something like that it may cause a different relationship because the person will look at you different. You start being judged and being a victim.

SK, Male, 45

As I said to you it's a trade off because if he doesn't disclose it to the nurse in the first place, nobody is going to know. So it's the best case scenario really whereas the other hand to me is if it isn't confidential and

he could tell it to the probation officer, like as you often do in these kind of things you say "Anything you disclose here could be disclosed to probation" I ain't going to tell you because I'm going to get in shit by doing it, whereas at least if it's disclosed to the health worker at least it offers some protection to the rest of the community whereas if he doesn't disclose it, it offers no protection at all does it?

CC, Male, 44

On the contrary, in favour of a non-confidential service the following comments were made:

The person who is on license, the NHS have a duty of care to let their probation officer know about their mental and physical health. I think that would work. If nurses don't tell their probation officer and that person with HIV started to pick up prostitutes in the area and then they're picked up for kerb crawling and then they're before the court, I think the probation Officer ought to know something like that. Because at the end of the day they have to give a report to the courts about that particular person if they're still on licence for recall.

BR, Female, 59

If you've got a health issue none of it should really be private. The more people know, the more advice you might get, the more help you might get with it. So I don't think there should be confidentiality.

SK, Male, 45

What was clear from participants response into how a confidential service should be run was that they felt that such a service should build on the established principles of data protection which govern the clinician patient relationship but that in situations where the health circumstance of the client could constitute a risk to the client or public, then this be disclosed to the probation officer:

Don't get me wrong they can't tell anybody else anything but they need to know in case you become suicidal, vindictive, like with HIV some people become very vindictive and at least probation can then help them get the right counselling or the right help to try and avert any problems like that do you understand what I mean? But just a run of the mill sexually transmitted disease or blocked arteries through pinning up, they don't need to know any of that do they? That's private.

NH, Male, 49

I think it depends on the nurse. If the offender is going to put his life at risk or he's going to do something to the public then she's got to tell his probation officer hasn't she? But if it's just maybe a small problem that's not going to affect anyone I think the nurse has got to weigh it up ain't she really? Whether he's telling her he's mentally ill and he's going to go and shoot ten people, she's got to tell his probation officer. But if he's just having problems with getting his prescription to keep stopping from rattling or if he needs his subutex or whatever, I think she can just sort of help him and then get his prescription without worrying his probation officer he's going to go out and shoot ten people.

SP, Male, 27

6.2.5 Silence dialogue: participants suggestions

This phase of the analysis evidences participants suggestions on factors which they posit can contribute to the continuity in access to healthcare for offenders in the community.

Participants indicated that they would like to see a 'life' support worker who ex-offenders on release could have a chat with around their presenting needs on an informal basis:

An ex-junkie would be good. I know there are people that have had problems that are in probation, why aren't they helping or giving advice rather than people trying to relate to other people? But the next best thing is for the people that want to be like that to at least be getting decent advice from people they've got some respect for, not the government because we don't listen to the government, the people with my outlook. Because they've told us that many lies about other substances, you can't trust them because they've only got their own interests at heart.

NH, Male, 49

I think that would be a very good idea. Because when you've been through it, you're the best one to say, to tell people and preach to them really aren't you? And people that turn out off the line, there's nothing better than them because they've been through them hard times and stuff. That is a good idea that is.

SP, Male, 27

Interestingly, the following comments illustrate the thinking of participants on the benefits of having a life support worker:

I need help with this. How can I go about this?" or "I want to go on a training course. How do I get in touch? Can somebody come with me?"
You know just that little bit of personal interaction. You obviously keep your line drawn you know between professionalism and social that line has still got to be drawn.

BR, Female, 59

I know when I was in XXXX they had the Saint Giles Trust and stuff like that and they have workers and they'll work with people coming out of prison to help them get housing and employment and support like that, and whether you could utilise somebody like that who has got the experience, someone who has been inside and has come out and help deal with it and whether you could utilise them to be able to put them forward so that when they are released you ain't starting from scratch.

CC, Male, 44

In advising the researcher on questions they would like the researcher to put across anonymously to members of the collective voices, participants indicated that members of the collective voices be interviewed on issues around access to a GP in the community, probation pre-release contact, and the nature of probation pastoral support.

Access to GP on release:

Part of their job is to help us resettle, stop us offending and to manage our behaviour and to help us reintegrate, so maybe as we were saying about the health issue, at least if they knew where we were living, they should have a database of doctors and stuff like that and could contact the doctors for us. If they had the added responsibility of it.

CC, Male, 44

I had to make my appointment to see a general practitioner, there should be something in place to get that set up beforehand so you haven't got to find your own. Because it was my own area so it was my old health service I still had to re-register with them, I think that should be done beforehand as well to make things more accessible for them. And I think there should be some sort of follow-on because they didn't seem to know anything about my health history, about my blood pressure and things like that from when I've been in prison which is stupid really. I then had to re-discuss it with them because they didn't have any of my history.

CC, Male, 44

Probation pre-release contact:

I think the probation officer should meet the offender personally prior to their release. So if you were my probation officer, to come to see me to introduce yourself I think that would help because you've got a face and you've got somebody that you can relate to.

BR, Female, 59

The probation officer can initiate you to start preparing earlier so that you're better prepared when you do get released. You're more organised, if there's an issue you know where to go. And is more of a friend through advisory, in other words there's somebody there that knows what they're talking about or has got a good idea, that can give you a bit of advice or that you feel comfortable ringing..... If you can breakdown that barrier before you get released, you could then really address any reoffending problems before it starts.

NH, Male, 49

In light of this participant's suggestion, a fellow participant indicated that they had contact with their probation officer prior to being released. However, it is important to note here that of the eight participants who were interviewed as part of the silent voices, only this participant indicated that they had been visited prior to release in prison by their probation officer:

She made an appointment with the office staff in the prison and then they told me when she was coming or I checked on the computer. Yeah. About three times.

DH, Male, 52

Probation pastoral support:

When participants were asked which questions they would like the researcher to ask members of the collective voices in reference to the nature of supervision received, participants noted that the nature of supervision received felt superficial as the process appeared to have no real world context and suggested that probation officers be given leeway to contextualise advice to their own lived experiences:

Well my probation Officer told me and he ought to be allowed to at least understand that advice is only that, that's exactly what it is, it's just advice. It's not telling you to do something, that's just their opinion of what they may do in that situation and he should feel more comfortable doing that. Actually you can put that down, why don't they use their experience and put it across to people as advice and let people understand that it's only advice?

NH, Male, 49

Following this further, participants maintained that the contact with probation on immediate release from prison was unhelpful and could be improved upon:

So probation can help you, if you can talk to probation and see if you can open a centre in here like a room or a big office like and talk to the people who have just come out of prison instead of just saying "Sign this, sign this, sign this, go on then, see you next week." That ain't going to do them. Don't get me wrong but I think it's been funny in the past year, come in here, "Sign this. Go on then. Anything else?" "No". I said "At the end of the day I don't have to tell you everything."

SP, Male, 27

In advising the researcher on interventions they felt could facilitate post release continuity in access to healthcare in the community, participants were unanimous in agreement that an open evening for health issues would be useful:

Because you'd find out what you can do and what you can't do and what you can say to them and get the questions that you need answering. That

would be good for me. Definitely for me because say what we talk about now I have to try and remember by the time I get out of the door and that's because I do forget a lot of things. So that would be helpful really.

DH, Male, 52

However, participants indicated that the timing and location for such an open evening would have to be carefully considered:

Near to the probation Service because everybody knows where the probation Service is, where they've got to go. So near to the probation. Or if they do a late night Probation it could be linked to the late night.

BR, Female, 59

It's probably going to sound very late to you but probably eight until nine something like that, or seven until nine. But you've got to catch people late because people who do drugs, people who are criminal operate late. They don't operate early, they operate late. There's no point having it at nine o'clock in the morning because nobody would turn up. Truthfully that's my opinion.

NH, Male, 49

Importantly, participants did not express concern on the potential for such a service to fuel the dependence of ex-offenders on the probation trust. On the contrary, a participant argued that the suspicion that this might be the case should not constitute a reason for not providing the service:

Hopefully once the issues are sorted out, they're going to be off probations hands aren't they? But not to offer it because it's going to fuel dependence on probation? I look at it at the end of the day you're taking

away somebody's liberty by putting them in prison, you've got to help try and re-establish them in the community which includes healthcare doesn't it? That's what it seems to me looking from an inside out point of view. I've known people get released and they haven't even got anywhere to stay. And they're like when they get discharged, you've got the money you've saved up "Ta-rah because you can't stay here no longer, that's your discharge date ta-rah" It's madness.

CC, Male, 44

6.2.6 Silence dialogue: uncovered silences

This phase of the analysis evidences the 'Silences' which were uncovered as a consequence of conducting this dialogue with ex-offenders. It is important to note that this study did not set out to investigate these Silences but on the contrary, these Silences emerged over time as issues which could potentially impact on the continuity in access to healthcare for offenders on release in the community. The Silences uncovered revolved around benefit advice, lack of a joined up working approach, the overworking of probation officers, trust issues and the cost of some primary care services.

Participants felt that having access to a benefit advisor could speed up their journey towards reintegration particularly if this individual could be accessed within the premises of the probation service:

Help with the benefits, because that's another big issue when you come out of prison. I had to sort my own benefits out, but in the male prisons

they've got somebody, not in all the prisons who helps with the benefits.... so I think if there is something here for healthcare and something for benefits within the probation Service, because we have to come straight away out of prison to see a probation officer and I think having those there would be a good opportunity for the ex-offender to get that information that they need.

BR, Female, 59

However, there appeared to be several instances where comments made by participants indicated a lack of joined up working between the health department in prison, probation and primary health providers in the community:

I think with the prison, with probation and with healthcare they all interlink and I think that's what's needed.

BR, Female, 59

The GP I signed up with was waiting for the prison to send my medical records back. Instead of giving them to me when I left in an envelope to give to my GP. And it was an eye opener put it that way. They gave me tablets to come out with but the main ones I needed was my depression ones and my painkillers, they just put them in an envelope with no name on them or nothing. And the GPs wouldn't recognise that as a proper medication. So I was stumped.

DH, Male, 52

Following this further, participants felt that probation officers may not be willing to take on any more extra roles because they felt probation officers were being overloaded with work:

They haven't got time to do anything else anyway have they? From what I understand, they're getting loaded up and loaded up and loaded up with things that really aren't their problem. I suppose that you could do something to streamline it a bit better for them couldn't you but from what I understand they're getting a lot of pressure to take on responsibilities and roles that aren't theirs. I don't know if I'm wrong but that's the impression I've got.

NH, Male, 49

In this context, another participant maintained that the supervision process has deteriorated in quality in the last year:

Don't get me wrong but I think it's been funny in the past year, come in here, "Sign this. Go on then. Anything else?" "No". I said "At the end of the day I don't have to tell you everything."

SP, Male, 27

It is indicative to note that this deterioration in the quality of supervision coincides with the restructuring and consequent privatisation of the probation service. Furthermore, whilst it was uncovered that participants did not complain about the supervision received on a personal level, they felt that total disclosure to a probation officer even around issues pertaining to health could unwittingly land them in trouble with the law:

So what I think is you need is somebody like yourself that's kind of separate.....I haven't got any issues and I think if I did the last person I'd want to discuss it with is a probation Officer because it will just make my life harder. So you're stuck in a bit of a circle. The probation officer is the access to getting help, helping you to become a better person or have a better life, and then you look at it from my point of view, well from an ex prisoner point of view that actually you're the one that could make my life a lot harder.

CC, Male, 44

Finally, it was uncovered that getting a dentist in the community as a non-paying patient was extremely hard. Although this issue was flagged up from the narrative of one participant, it is crucial to note that most ex-offenders do not have the means to access dental care as paying patients. Accordingly when they have a dental problem how exactly do they cope?

Well the first part is, that it's hard to get a dentist. You can't get a friggin dentist. Nobody wants NHS, people that aren't paying. I don't earn enough to pay so I don't know what I can do. I can't afford to pay it so. If you're signing on at the dentist, registering at the dentist, first thing they ask you is "Will it be NHS or will you be paying?" You know what I mean, cash. I did try going in cash, so paying the first payment and then going onto NHS, they didn't say they weren't going to see me but they weren't very pleased about seeing me you know what I mean so?

NH, Male, 49

6.2.7 Questions for collective voices

The following questions informed the interviews conducted with members of the collective voices. These questions emerged from the silence dialogue conducted with ex-offenders and are the study draft 1 findings as indicated in the methodology chapter. These questions were asked to analyse the diversity of evidence collated from ex-offenders in the silence dialogue towards providing an insight into the potential generalisability of the research findings. In addition, these questions were also used to explore the Silences which the collective voices maintain still exist bordering on the continuity in access to healthcare for offenders on release from prison and issues which they feel can mitigate against the provision of a nurse led service for offenders on release in the community:

- What are your thoughts on the pre-release support received by offenders in preparation for accessing health services on release?
- The participants interviewed maintain that the probation trust would be an ideal location for the provision of a nurse-led service. What are your thoughts on this?
- If we did decide to provide a nurse led service, would you prefer the service to be provided on an appointment basis or as a drop in centre and why?
- How would you recommend a nurse-led service operate with regards to data protection?

- Family support was found to be crucial in helping individuals access health services on release. In cases where individuals do not have this support, what in your experience have you observed has being helpful to them?
- Participants recommended that any provided service should operate on an advisory level as a sign-posting service. What are your thoughts on this?
- Participants recommended that an open evening around health issues would be hugely beneficial. What are your thoughts on this?
- Participants recommended that probation officers do more in helping them find a GP in the community. What are your thoughts on this?
- Participants recommended that probation officers get in touch with them in person in prison prior to release. What are your thoughts on this?
- Who else can you recommend I speak to? An individual in your opinion you think their expertise could inform the outputs of this study?
- Would you like to share anything else with me?

6.3 Phase 3 – Collective voices

This phase of the analysis commenced after the production of draft 1 findings (semi structured interview questions to be asked to members of the collective voices) and involved the analyses of the scope and diversity of the evidence generated via the

silence dialogue. The objective here was to sample the opinion of individuals in the social network of ex-offenders, and others whose social, cultural or professional situation impacted the lived experience of ex-offenders in order to add, corroborate or refute the issues uncovered during the silence dialogue.

Findings were generated to mirror the structure under which findings emerged in the silence dialogue. At the conclusion of this phase, draft 2 findings were generated. These gave an insight into the potential generalizability of the research findings which emerged from the silence dialogue. These draft 2 findings are presented below. An additional aspect of the exploration of the findings here includes the reflection by this group as to the 'Silences' they consider still exist or remain unchanged as a result of the study. These reflections served to provide additional insights which informed the fourth phase of analysis which is discussed in the next chapter.

6.3.1 Before release

This phase of the analysis explores collective voices construction of the pre-release experience of ex-offenders towards uncovering the nature of pre-release support received and the consequence of received support on their ability to access health services on release in the community.

In contradiction to the silence dialogue, the collective dialogue indicated that while access to healthcare in prison was good, the delivery of health interventions was inconsistent and varied from the immediate provision of services to the non-delivery of services:

I've had somebody who has come out on license a few months ago and he was complaining about some problems in prison but he says that they took ages looking into it and it's only when they were about to release him that they offered him an appointment by which stage it was too late because he's back in the community and he can sort his own appointments out then. And since he's been in the community he's been diagnosed with cancer. So he's saying if they'd been more proactive in the prison then he probably wouldn't have got to the stage that he is now.

Probation Officer

I can only speak from prison experience not community. We provide an exit interview which is by a band 4 STAR worker in healthcare. This provides the patient time to discuss their health concerns for release, have a copy of notes, links other services eg mental health to inform of their discharge and arrange order of their medications. This is great and other prisons do not provide this, I think this could be expanded on eg link up with GPs and fax notes straight over but like you said without an address you can't register which then prevents us.

Prison Healthcare Manager

However, it was clear that even when offenders received treatment for a health condition in prison, the interaction with the healthcare practitioner and the treatment received did not prepare them for the continuity in access to healthcare on release:

I think my perception would be that most of the time people get the treatment or get access to treatment in prison. I don't think that it is then

backed up in terms of them being educated or making it clear on how they can access such support on release. I think there's an assumption that people will register with the doctor. I think there's an assumption that people will be able to describe what's wrong with them, maybe an expectation that they know what they've been taking before and I don't think that's always there. So it's not translated to when they come out in the community I would say.

Probation Officer

Furthermore, the collective dialogue indicated that revolving door offenders were most likely to not complete treatment for a condition diagnosed in prison:

We'll start work with them to do with getting control of their diabetes, getting control of their hepatitis C, that sort of thing. They're then released, go back into the chaos of post-release life, get arrested, come back to us and we're starting from scratch again. So we've got maybe one or two prisoners at the moment that have got resistant TB and they've started treatment via us, been released, having followed up, come back to us and then they can't continue treatment because the TB has become resistant to the treatment that they were originally given.

Criminal Justice Nurse

In alignment with the silence dialogue, the collective dialogue indicates that the pre-release support received by offenders in preparation for the continuity of access to healthcare was not fit for their presenting health needs on release. This view was similarly shared by the collective voices:

There isn't really. It's about people finding their own way and we can signpost them but we have no means of sort of helping other than signposting and it's a frustration. I mean obviously there's the health teams within the prison and in terms of people's medication or sort of plans for their future I know that there are links made if you like but that's assuming that somebody has got a GP and that individual offenders will be taking responsibility to follow up on their own health needs and that's not always the case.

Probation Officer

In the past 12 months I was an A&E sister so I had a lot of experience with ex-offenders coming into the A&E department. And a lot of them would be, they've got nowhere else to go, they've come here because we're the last resort, they haven't got anywhere to live, they haven't got access to medical care. They need the drugs because they were put on a drug rehab programme in prison which then it's not been followed up when they've been released from prison. And they just feel that a lot of them, as soon as they get out, that's it, bang. You're released, you're a member of the public, we don't want anything more to do with you. But my concern with them was the fact that if they didn't get that treatment there they were coming to us in the A&E department.

Acute Trust Nurse

Crucially, it was uncovered that the collective voices consistently qualified pre-release preparation in the context of mental health and substance misuse but not physical health. However, it was clear that steps were taken by both prison and

probation officials to ensure that continuity exists in access to healthcare where it had been identified that an individual was about to be released with a significant health need:

I think the pre-release support that they get in custody is quite good. I've certainly been contacted by prisons about offenders who were due to be released back into the community and I know that they've made links into the community to continue with that support dependent upon the individual's needs. So I found pre-release support quite good. Predominantly, mental health, drug and alcohol issues.

Probation Officer

The only time that would come into play is if the individual has been identified as having health issues in which case what would then happen is that there would be frequent liaison communication ongoing between the internal OS Offender Supervisor and the Offender Manager. That would be in as I say exceptional circumstances, I've got one currently who has been identified as in the early stage of dementia and so we have got current ongoing dialogue with him as well as the internal health service resident in the prison and also externally I have been in touch with the Social Services because they have to get involved as well so that is the only time when as a probation officer I've had to get involved at that level.

Probation Officer

It is important to note here that although the overwhelming view was that the pre-release support around physical health aimed at ensuring that offenders continued to

access healthcare on release appeared to be non-existent, this in part is caused by the sheer volume of offenders released on a daily basis and the conditions which surround release across the prison establishment:

In the worst case scenario which is in the majority of Category B prisons, which are largely in inner-cities, often people can get released on the same day so they will attend a video court which is occurring in the prison, which release them, and I think the prison is legally obligated to help them leave the prison. I think within two hours or three hours, it's something like that. At that point health may or may not know that that is happening. So there's a group of people that falls through the net at that point.

Prison Healthcare Inspector

Concerns were raised with regards to the supervision provided by offender supervisors in prisons in both the silence and collective dialogue bordering on the inconsistent nature of the supervision they provide:

Sometimes you get lots of information from Offender Managers, sometimes you can't. And sometimes you phone up "Can you tell me what Joe Blogs is doing?" "Oh yes, blah, blah, blah" other people "Oh I've not seen him yet, I don't know anything about him" so it is very hit and miss.

Probation Officer

So even though they may not have had enough opportunity to engage with their Offender Manager while they're in custody prior to release I know I think it's a good thing that we visit them at least one time to make sure that we set some kind of atmosphere.

Probation Officer

While it is acknowledged that the supervision provided for offenders during imprisonment could be improved upon, it is important to note here that members of the collective voices maintain that there is an economic explanation for the present status quo:

But with resources as they are it's having to prioritise perhaps the people who are already in the community that there has been a definite shift away from the wellbeing of the offender being the overriding concern to more about sort of risk to others, protection of the public. And so therefore your cases in the community are going to have a priority because that's where the risk is at its greatest.

Probation Officer

Furthermore, it was uncovered that while the data protection act made it difficult to obtain information on the health statuses of offenders, offender supervisors were rarely aware of the physical health needs of the offenders they were supervising and consequently could not convey this to probation officers:

One problem that I find is that healthcare, it's hard to get any information. A- because of data Protection but even then they're very hard unless it's mental health, they're not going to tell you anything about their physical health at all. Other than you might get the information on their medication and that's it. But in terms of with the supervisors inside not really.

Probation Officer

Furthermore, it was sobering to uncover that the relationship between offender supervisors in prisons and probation officers in the community did not always exist on any level:

The communication between prisons and probation officers outside of prison is very far between. Sometimes the prison has just released them; we don't even know that they've been released until they come here. That's a sore issue. That needs to be sorted. We have a HDC that says 'Yes they're going to be released about this time' and there's a date but that date is like lengthy.

Probation Officer

I think my thoughts in terms of that role is that the Offender Manager on the outside and the Offender Manager on the inside have a lack of communication. And we don't liaise enough between ourselves to say "How is Joe Blogs doing? Has he got these physical health problems or has he got these mental health problems?" or whatever. We work in isolation essentially. We don't sort of say "No we're in this together". I think that's going to get worse because of the privatisation because that's NPS and that's CRC so that would be my take on it.

Probation Officer

6.3.2 On release

This phase of the analysis explores collective voice construction of the on-release experience of offenders in preparation for accessing health services in the community.

It was established in the silence dialogue and corroborated in the collective dialogue that the on-release preparation for offenders did not enquire as a matter of procedure whether an individual was registered with a GP or had the agency to register with a practice on release:

I had someone in the walk-in centre the other day who hadn't registered with a GP, been out of jail for a few months and he quite happily told me. I asked him 'Why haven't you got a GP?' and he said 'I've just come out of jail'.

Acute Trust Nurse

Clients with physical health needs I found as I say, they've been given the medication in the morning, given a couple of tablets and said "Right there you go, go and see your GP when you're released" and that's not always easy very often clients can't get an appointment for a long time or they've disengaged with the GP and they're not registered anywhere or they've moved to a different area.

Probation Officer

It is important to note that the collective voices indicate that the bone of contention is that even in cases where detained offenders have been instructed on how to register with a GP, this is not being done on release into the community:

The minimum we expect to see and generally it does happen is that prisoners are given instruction as to how to go about being entered onto a GP list. And also a dental list when they leave. But of course the reality of how many actually do anything about it is probably (no good to you?) I'm sure.

Prison Health Inspector

I mean we advise all of the time, we always say "Oh you need some help with this, let me make an appointment for you, or let's phone them up and let's get you in there" and then the client doesn't go. And so we'll do the advisory bit and signposting but the client doesn't go. So we can have somebody giving lots of advice and some clients will go and take that up and some won't. I've lost count of the amount of times people haven't been registered with a GP, they don't want to know, they don't want to register because "Oh I'm not going, I've got to wait and go to the Walk-In Centre"

Probation Officer

However, it was uncovered that as part of the induction which is conducted by probation, a key question which is asked is whether an offender has a GP in the community with action taken where it is uncovered that they have no GP:

One of the key questions we ask when we do any induction is "Do you have a GP?" and if not we look at GPs and give them a list of GPs within the area.

Probation Officer

You know I do in my inductions; I make sure I bring it up to them, "When is the last time you've been to a doctor or seen a doctor?"

Probation Officer

Nonetheless, it was uncovered that even when offenders were signposted to a GP in the community, overwhelmingly they were getting rejected due to their lack of a fixed abode:

The problem with that is that if they don't have stable accommodation they can't register with a GP because very often GP practices will only take people in certain areas, I know that's supposed to be slightly changing but very often they can't get onto a GPs surgery because they don't have stable accommodation.

Probation Officer

It was also uncovered that offenders were being refused registration with GP surgeries in instances where they lacked a means of identification:

I know clients who have been in to register and they can't be registered because they've got no ID and it's a nightmare for clients to try and get registered.

Probation Officer

Crucially, where offenders had been signposted to be registered with a GP at induction by their probation officer, it was not always followed up by the probation officer that indeed this had been done:

And maybe then also do a follow up thing where you say to them if they've taken away the form and said that they will do something is for the officer to check "Have you done that?" I know that because a lot of them move around so often that they're no longer anywhere near where they've originally had a GP so it is an issue.

Probation Officer

However, the collective dialogue indicated that it was not the role of the probation officer to facilitate registration with a GP surgery. This dialogue indicated that making this a role of the probation officer would be counterproductive to the ethos of resilience which as probation officers the supervision they provide is designed to instil:

Realistically speaking right, I think it would be difficult, it would in my view add more pressure on what we already are actually having to do and especially if someone has nowhere to go and you're rushing frantically trying to assist when you have a number of other competing priorities and then to having to then go on the net and look for a GP etcetera, etcetera. It's time consuming, it's not entirely feasible. I'm not saying it couldn't work but certainly to put it as a requirement for probation officers to do it's a bit of a tall order really I think. We try to empower our clients too and I think they need to take responsibility

Probation Officer

In addition, the collective dialogue indicates that there are no clear pathways for the transfer of patient clinical records between prison and primary care:

All prisons use SystmOne an electronic system, and many GPs do nationally in Britain, so why they can't be linked one doesn't know? But it is a very significant issue and the best we see is where summaries of SystmOne or if necessary detailed records sent to the GP obviously with the prisoner's consent prior to the prisoner being discharged. That's usually done by fax but why it can't be done electronically is really very perplexing? And the reciprocal is true as well you know records coming into the prison from GPs that is often a problem.

Prison Health Inspector

A lot of the people we deal with perhaps have difficulty having a coherent understanding of their own health needs. Perhaps have difficulty with a coherent chronology of their health needs and treatments. Or possibly knowing this but having difficulty expressing it, particularly in a five minute appointment with a GP who maybe they haven't met. Now if their medical records can be accessed anywhere over the country by GPs that helps doesn't it?

Probation Officer

Furthermore, the dialogue maintains that what exists for the transfer of these records is a process which is dependent on the offender having a GP in the community:

In terms of general medical continuing support, the person would have to approach their GP and that GP would have to request information/records from the prison services and the person concerned would have to sign a disclaimer allowing that to be. The person separately to that will be provided with a document with some information on whatever medication or anything else they were being treated for to take to a GP.

Probation Officer

However, the collective dialogue further indicates that the provision of temporal registration for offenders on release, with a pre-established surgery in the area they are being released into, could facilitate the continuity in access to primary care on release from prison:

People could be directed from prison, if you had some sort of central GP then homeless people could go there, people who were not yet registered could go there and from there they could go to the more stable practices possibly. And that would be available to people out there who have similar issues of ability. So that could be important. It could be anywhere. And then it's there and then the person will know that's where to go.

Probation Officer

Maybe a GP service that's like set up purely just for catchment of areas of repeat offenders that have been released. They've got like a month access to a GP service, after that month access they can start on another development plan. But for that month, the first month that they're out that

they're more likely to reoffend or go back to reusing, they've got that point of care that they can go there.

Community Nurse

Crucially, it is important to note here that members of the collective voices felt that not being registered with a GP on release was fuelling the use of health services by offenders in a crisis led way:

The difficulty with many offenders who are not registered with GPs is that they utilise the A&E department at hospitals as a GP surgery which is a misuse of the NHS resource, very costly, very inefficient and also could be very negative in stopping other people more needy getting the service they require in a swift manner. So a vested interest in being part of the community is having a registration with your local health service.

Offender Health Commissioner

6.3.3 Post release

This phase of the analysis explores collective voices construction of the issues supporting and mitigating against the engagement of ex-offenders with health services in the community.

Collective voices maintain that post release there was a clear disparity between services which addressed the physical health needs of ex-offenders and those which addressed their mental health and substance misuse needs:

Clients with physical health needs I found as I say, they've been given the medication in the morning, given a couple of tablets and said "Right there you go, go and see your GP when you're released".

Probation Officer

At the moment from a substance misuse point of view and a mental health point of view there is policy and procedure in place that stipulates that there has to be a follow up appointment, especially with substance misuse with people on strong opiates and that sort of thing but not for anything else.

Criminal Justice Nurse

In addition, it was uncovered that the practice of moving prisoners across the country to accommodate risk unwittingly leads to a situation which inhibits their ability to continue to access healthcare on release from prison:

On top of that we have a prisoner movement system that actually governors are moving prisoners around the country regularly in order to manage risks, to manage issues within custody and that has an impact.

Probation LDU Head

And again there are things like patients with cancer and those sorts of things. And in regard to that one of the big problems that we have is a prisoner can be put in a prison anywhere in the country, whether it's close to their address or not. So then we can arrange for appointments within the local hospital, local trusts to have stuff done while they're with us but then come release they then go back down the country or across or

wherever it is that they're getting released to and that then all starts over again for them and we don't have any say to that whatsoever.

Criminal Justice Nurse

Indeed, this movement creates a situation in which Clinical Care Groups become unwilling to accept financial responsibility for offenders on release from prison:

This is a problem in the prison service because of course prisoners are moved around by the prison service so they are often out of area. So often it's difficult to get clinical care groups to accept financial responsibility for people.

Prison Health Inspector

Furthermore, the collective dialogue indicates that in addition to the lack of interventions aimed at addressing the physical health needs of ex-offenders as a unique group, the practices of probation officers are skewed in favour of addressing the mental health and substance misuse needs of offenders but not issues pertaining to their physical health:

We just act as conduits for the clientele in terms of 'We'll pass you onto this expert, we'll pass you onto that expert. And we're very good at doing it in terms of mental health and alcohol and drugs misuse but perhaps don't look at things like physical health.

Probation Officer

6.3.4 Collective voices: nurse led service

This phase of the analysis evidences collective voices views on the provision of a nurse led service for custodial based ex-offenders as an intervention aimed at addressing their health needs post release.

The collective voices indicate that a nurse led service could facilitate access to primary care and could create a situation in which custodial based ex-offenders could immediately seek advice on their health in response to a health need:

That would be good because then the nurse could do an initial assessment as to what that person's needs are and then they could be signposted to services in the community because there can be a bit of a gap there where a client will come to us with complaints and that's when we'll say "Have you spoken to your GP?" and they haven't necessarily spoken to their GP and you probably see them again a week or two later and they're still complaining about the same thing and they haven't been to the GP. So probably having a nurse here would encourage them, would act as the bridge between here and the GP.

Probation Officer

I think it would be a good thing. Reason being here again we have a government building, its dealing with prisoners; it's dealing with offenders that need help in the community, and having the community nurse available to do regular check-ups on someone who we know has got problems. We have CPNs who are registered here, why not a health

nurse that we can go to if we have an immediate need? I don't see a problem in that. I think it would be a good thing.

Probation Officer

In addition, participants also felt that a nurse led intervention had the potential to improve ex-offenders perception of probation, situating probation as an organisation which is empathetic to their health needs:

If we could have someone here I think that will send the message that it's a probation thing and we'd know more about the individual and I suppose it presents less like we don't care, I presume some people may think that.

Probation Officer

However, it was also uncovered that certain members of the collective dialogue were keen to construct a nurse led service as a means of supervision:

I think that would be good because the nurse will know about probation, what sort of information that we need and also we can monitor the health and attendance and we can use it as appointments as well. So I think it's a great idea to have it here.

Probation Officer

if we have clients coming in to the scene we'd have to try and assist in terms of better referrals because although we've perhaps informed them of the facility and because they're under supervision then coming in to see someone about their health could also be part of the supervision if you like, although they're not actually seeing the probation officer or offender

supervisor and then they're given time that could be used as an official contact in that respect.

Probation Officer

It is important to note here that the aforementioned views were not unanimous, and indeed were contradicted with certain voices in the collective dialogue arguing against using the service as a means of supervision. These voices maintain that associating the service with the criminal justice service is counterintuitive and contradictory to the principles of healthcare provision:

I don't think it's something we can make mandatory as part of a court order because it's about a client that's got health problems like mental health problems, it sits uncomfortably. From my point of view it's their choice. If they've got to do a programme because they've offended that's fair enough but with this I think it should be done on a voluntary basis. 'This service is there for you, we can talk about it and the ball is in their court'. It's not something that we should make compulsory or anything like that.

Probation Officer

Having said that part of their license conditions are that they could be ordered to attend appointments with a healthcare provider, that doesn't quite sit well with ethics and the sort of ethos of how we work.

Criminal Justice Nurse

It is suspected that the collective voices who constructed the service as a means of supervision did this in response to the increased work pressures placed on probation officers. However, the evidence to support this is not available. Furthermore, whilst members of the collective voices agreed that a nurse led service has the potential to contribute to the improvement of the healthcare of ex-offenders on release, there appeared to be concerns on the need for the service, public perception of such a service, and the potential for such a service to fuel dependence on the probation trust and consequently work counter to the principle of resilience which the supervisory process is designed to instil in the offender.

The need for the service:

It shouldn't be necessary. I think that's why I pull back from it. In an ideal world with lots of resources to actually have a separate additional resource for people in the circumstances we deal with, it feels to me as if it shouldn't be necessary. So empower the individual that's where I'm coming at it I think rather than setting up a plaster and putting a plaster on a problem that is less about empowering the person, of course it would be easier for me to say yes? But to have it as part of that pre-release process and given the information about how you find out where a practice is, what you have to do.

Probation Officer

In the present economic climate and with all budgets being squeezed and with all posts needing to be utilised to the best of their ability to deliver value for money and productivity, I can't envisage a nurse-led service

being co-located in a probation office ever having sufficient demand to require a dedicated service.

Offender Health Commissioner

Public perception:

I don't think it would go down very well with the general public. Because they would say 'Well how come they've been in jail, they've done something wrong, they get released but yet they have a specialised clinic that they can go to at any time at any point'. And they don't see the whole picture, they just see that them getting their right treatments and the right time in the right place, but yet the little old lady that lives down the road has to wait several weeks to see her specialist consultant.

Acute Trust Nurse

Dependence on the probation trust:

And the worst thing I think probation can do is to make people dependent on probation. Because we have a lot of services here as you know, partnership agencies come in and deliver services and clients get used to seeing people here and doing work with people here and then the probation or the license finishes and it's like everything disappears with it and I think that's very harmful.

Probation Officer

People who commit offences who we deal with don't know that it's available, they don't know how to access it and if they persist in accessing it via us we're going to perpetuate the dependency on the criminal justice system. I think being on probation the best thing that somebody can do in

their life is not need a probation officer and that's where I start from. Don't need me. Get rid of me. Learn how to not need me and not to come near me.

Probation Officer

The collective dialogue also questioned the rationale behind having a nurse lead the service in the context of the present economic climate and argued that the proposed intervention could be delivered by a health support worker or an administrative staff seconded from the NHS to carry out the role:

Whether that has to be a nurse because what we're providing is advice and guidance. I guess looking at cost and funding it would probably be a more efficient model to have that led by a support professional rather than a qualified nurse.

LDU Head

Well logistically it's not something that could just happen at a whim. It would require plenty of research and planning and also looking at the possible take up because it's okay if certain offenders say that they would appreciate that but the question has to be, how cost effective would that service be? Because okay if you have something in situ but that is not being actually accessed properly it could be just sort of money being thrown at a cause which is not being readily I think consumed by those offenders or consumers.

Probation Officer

On the contrary, this position was countered by voices who indicated that the role will be better performed by an individual with clinical training:

I think to make it work optimally to begin with it would be wise to have a clinician in the role or certainly have the service under the direct control of a clinician. You will find people hiding behind medical incompetence and all that kind of stuff..... So I think initially to set the service up you ought to have clinical involvement or have an administrator type person, healthcare assistant, whatever working to a clinician. So certainly GPs can be informed if they are being a bit fractious that they're talking to another clinician. You can't hide behind transferring information or not transferring it because it's medical incompetence which is a game they often play.

Prison Health Inspector

In addition, it was also suggested that an alternative to providing a nurse led service, would be to establish clear referral pathways into the local NHS to which probation officers can refer clients into:

I think some protocols with the local NHS services and clear care pathways would be the way to approach it.

Offender Health Commissioner

However, other voices in the collective dialogue argued on the contrary and posited that a nurse led service will be cost effective compared to having the service run by a support worker or administrative staff. In this context, they maintain that the nurse already has the training and expertise which will have to be provided to the support worker at a cost:

From a nursing perspective that's why I think a nurse-led service would be good because you've got those skills already because you're trained up in that. You know how to build rapport, you know what's really serious, what's not. And you do all the ethics and that sort of thing whereas maybe someone coming straight from the street to lead in the service as it were hasn't got that level of knowledge or the skill.

Criminal Justice Nurse

Obviously healthcare assistants can't do a lot of jobs that nurses can. Nurses have got a lot of anatomy and physiology. They know a lot more about the drugs that are given so for diabetes and stuff like that. A lot of nurses ask why, they're trained to understand the reasons why they're doing these things. Unfortunately I think health carers are fantastic but don't always enquire any further to what they're doing. So maybe nurses have got the background knowledge more. I'm sure there will be a place for healthcare assistants like phlebotomy, just basic wounds that sort of thing. But I think a lot of the chronic diseases really should be down to the nurses.

Community Nurse

Furthermore, certain voices maintained that the service would be most effective if the nurses employed in the role established contact with the offenders prior to release:

I think it's a really good idea. I think that it has to be done and initiated and started with the offender before they leave prison. I think if it's something that's going to happen two to three weeks after they leave, I think that's

too late. I think it has to be started say a month, maybe even two months before their release date. You know that the nurse gets involved with her team working alongside the probation service to then fill that gap.

Acute Trust Nurse

I think they should be getting that support at least a month or so and possibly earlier than that before they're released they have a plan in place.

Community Nurse

In addition, participants felt that the service might not be supported if it was not aligned to the strategic objectives of commissioners:

I'm not quite sure which way it would move? Especially with CRC they're private, they may see it's beneficial to have it and fund it or they may say it's not their primary goal. Similarly with NPS as well, who funds it? And that's going to be the problem and I don't know what the answer is as yet. So that is interesting. I think it is important for both sides but the impact is anyone's guess at the moment.

Probation Officer

Interestingly, the aforementioned comments illustrate the uncertainty governing the restructuring of the probation service nationally. The following comments are also indicative of this:

Obviously with the split in resource I guess it would have to be an agreement between NPS and CRC about what they would contribute.

They can't agree on nothing at the moment. But it's definitely something that CRC would be interested in. It might be that you speak to XXXXX who is our district manager. He may have some ideas, I don't know whether XXX would be in a position to make a decision but if he doesn't know, then he will know who you need to speak to. But other than that I really don't know and there's XXX for the CRC, there's also XXXXX for NPS. And I don't know whether that's a joint decision that they'd be making I don't know. This brave new world of ours I don't know what's happening.

Probation Officer

The changes as far as I'm concerned aren't necessarily a good thing for a variety of reasons but it's had a negative effect on some staff and the sickness records on the staff has gone up by a considerable margin. What effect that has had in terms of the staff that are left, they're left to pick up the same sort of caseload with the added pressure which in reality means you can give less time to your clients and because of that you may not be addressing and meeting all their needs. So from that point of view, I think it's had a negative effect in terms of where we are at and where we were as one organisation before this sort of rule and divide now.

Probation Officer

However, in the commissioning of such a service, participants maintain that it is important that commissioners give the service sufficient time to become established

and not evaluate the success of the service exclusively on the numbers that attended:

A lot of times we start these projects and it goes for three or four months and all of a sudden because we haven't got the numbers up all of a sudden it's gone. This is something that if you put something in place, leave it in place. But it's the funding again, it brings it back to funding. It takes time for people in the community to recognise yes there is a resource that I can use but it's not given time a lot of times to be established. And when something is established it has to be there for time not just because there's a bit of money here so we'll throw that in there and when some of the money is gone it's gone.

Probation Officer

Whether or not it has any sort of long term realistic possibility is another issue because then they may set it up or start it off and then like most stuff the facilities that we sometimes put in place it's sort of only for the first season, it's time limited. Because once the users are not accessing it appropriately they will have managers having to review and then make decisions about whether it should continue.

Probation Officer

Furthermore, the dialogue also indicated that any individual employed in the role must be conversant with the primary care services which exist in the community and the referral pathways into these services:

It's just getting to know the services I think that's what you'd really need to do. Is just get to understand the services and what's really out there. Obviously nurses are not there to diagnose so they won't be referring or signposting to consultants but it's just having an understanding of what's out there I think, that's what training they would need probably.

Community Nurse

Importantly, the collective dialogue maintain an alignment with the silence dialogue that any provided service would have to operate as either a drop-in service, appointment service, or jointly as an appointment and drop-in service. Collective voices in support of a drop-in service consistently cited the chaotic lifestyle of ex-offenders as the rationale for their choice:

I think there are benefits to both but given the chaotic lifestyles of some of the offenders perhaps a drop-in might be the best way of getting them because if you give them specific appointments as you're only too aware, they don't keep them.

Probation Officer

I think one of the issues with it being an appointment service is that if you're dealing with people that haven't for whatever reason registered with the GP and they're reporting to probation and the health issue has been identified or they've raised it, for there to be an appointment service where they've got to come back again chances are unless it's to come to the next probation appointment which is in a weeks' time or what have you, chances are that they might not keep that. So if it was done on a basis

where we'll deal with the presenting issue and then follow it up with referral to a GP and get you registered with a GP, I think perhaps more of a drop-in service would be better.

Probation Officer

On the contrary, collective voices in support of an appointment service cited the need for order, control and building resilience as the underpinning reasons for their suggestions:

So a drop-in would not facilitate that, it has to be official so if you make an appointment for them to come in, the appointment is crucial then you have to have some sanction attached to it. A drop-in centre is voluntary, they can either take it or leave it whereas however it is made official and you give the appointment system again you have a benchmark against which they have to show some commitment so they come in and really utilise that service otherwise again what's the guarantee that people are going to use it?

Probation Officer

I think an appointment led service would be preferable for a number of reasons. People have to take responsibility for their own health needs and I think that having a drop-in centre is fantastic and we know that the drop-in centre in xxxx itself is invaluable but they're there specifically to do that job, they're funded for that, they're resourced for that, it's set up and it's running. Whereas appointment based ones tend to be more focussed, we can't make people take medical advice but we can sort of encourage and

we can even say "This will be your appointment for the week" so it will be a way of just encouraging people to be a bit more responsible so my view is an appointment would be better.

Probation Officer

Collective voices who favoured the provision of the service as both an appointment and drop in service indicated that providing the service in this format recognises the lived realities of ex-offenders life on release (Chaotic lifestyle) while concurrently trying to imbibe them with the agency to navigate health services independently:

I think both if that makes sense. Obviously some people will drop-in but I think structured is always better because it gets them into a routine. So I can see the positives of both really. So I know the housing advisor does structured ones and then a drop-in for a chat. So there might be benefit in that as well.

Probation Officer

I think it's a case of doing both to be honest. I think to allow people to drop in would be good because there is that chaos in their life and in the initial parts and they've got lots of other stressors that they will see as more important in their life than their health which is fair enough. But then also if you are then building the rapport and looking at case managing someone even if it's a case of you do the primary care bit for them but case manage the secondary care appointments for them to make sure that they aren't getting dropped off waiting lists and they are getting access to stuff. I think

it would be a provision of appointments for that to make sure that you're able to spend the time to be able to do that.

Offender Health Commissioner

It is important to note that the collective voices were unanimous in maintaining that the timing of such a service irrespective of the format in which it is to be provided would have to be flexible:

I mean a lot of them don't necessarily like getting up early in the morning so they might be more inclined to take advantage of it if it wasn't such a rigid appointment system.

Probation Officer

Furthermore, the collective voices felt that the provision of the service as an advisory and not a treatment service was in line with the ethos of not fuelling dependence on the probation trust and not duplicating existing services which already exist in the community:

I think the treatment services are there and actually it's navigating people through the system. So my work with the commissioning group in xxxx would tell me that there are sufficient treatment routes but because we're not clear of what the routes are and how we navigate offenders through those routes, I think if we provided a treatment service we'd be duplicating what's already there. So it's advice and guidance stuff I think that's necessary.

LDU Head

I'd imagine it would be advisory or signposting to be honest because you're kind of empowering them to access the resources in the community then rather than coming to probation for everything. Because really probation is somewhere they want to be getting away from ideally.

Probation Officer

Whilst majority of voices in the collective dialogue were in support of having the service structured as an advisory one, some voices in this dialogue argued on the contrary and felt that adding a treatment component to the service was worth considering. These voices maintain that ex-offenders who use the service may have the contact with the nurse as their only contact with a medical practitioner due to their chaotic lifestyles. In addition, these individuals felt that adding a treatment component could potentially ensure that the service is taken up and will provide better value for money:

I think the problem that I get with signposting is they've come to you today for help and advice and you're sending them somewhere else. They might not have the time to go somewhere else. If they're saying 'I really feel like I need to use' if that feeling overwhelms them and they're coming to you for help at that time they're just going to feel like you're pushing them 'Oh she's not bothered, she sent me somewhere else' you know I think that if it's going to be a service you're going to have to do it properly where the first point of access is just that, the first point of access. If you signpost them somewhere else a lot of them are going to fall through the cracks.

Acute Trust Nurse

And as far as advice goes for accessing health things that's something that their probation Worker can do and does with them anyway, they can signpost. If they're saying "I've got this problem with this" part of probations job is to signpost them anyway. So what's your value added by having a health advisor there that can only give as much and do as much as what probation are doing anyway? I think you've got to have something that's a bit more than that.

Criminal Justice Nurse

However, in the provision of the service on an advisory and signposting basis, it is important to note that this could potentially lead to conflict between the patient and the primary care provider. Accordingly, nurses employed in this role will have to be aware of this, tailoring their practice towards ensuring that this does not happen:

But I know a lot of the people I've met over the years would be very inclined to say they didn't do it for me, they wouldn't do this, it didn't happen that way when actually they have played a part in that falling apart. So it could place that broker with quite a lot of work.

Probation Officer

It is important to note here that participants felt that the potential cost consequence associated with designing the service as a treatment service was an issue they thought could potentially affect the funding of such an intervention:

I doubt whether we'd get the funding to set up any kind of proper treatment.

Probation Officer

However, it is important that any provided service whether it is treatment or advisory put in place mechanisms to follow up on delivered interventions:

So I think the advice is very good but then is somebody going to follow that up to say "Okay I saw you last week how have you been?" is it going to be by phone call, "How did you get on? Did you go?" and whether that's us following that up or the nurse-led service follows that up and just checks out that client was okay with the service, some sort of follow-up.

Probation Officer

In addition, the collective voices maintain that the individual employed in this role must come with a working knowledge of the referral pathways to the primary care services which exist in the community:

But I should imagine that what they would probably need to do is have a bit more understanding of what's outside in the world. If they've worked with inmates, they've probably worked inside the prison, not on the outside of the prison. So for me if I was the nurse I'd want to know my links. I'd want to know the people I'm referring to.

Acute Trust Nurse

Although the silence dialogue indicated that ex-offenders would like to see a nurse-led service sited within the premises of the probation trust, the collective voices were not unanimous in agreement on this. Those voices against siting the service on site indicated that while it may be beneficial to have the service sited in the probation trust, doing this could fuel the dependence of ex-offenders on the probation trust

when indeed their supervision is aimed at imbuing them with resilience and the agency to integrate smoothly into the community. Indicative comments include:

Two things with that. On the one side it's very good if it's here because we can make sure that the client accesses that because very often we'll say "Go to the Walk-In Centre" and signpost them on and they don't go. So that would be good if it was here but the other issue is: it's about not making clients dependent on probation.

Probation Officer

My preference would be to have it out in the community and to perhaps have some sort of nurse-led intervention but not based here so we can phone that nurse and say "Mr Blogs is coming to see you today can you confirm that he has attended? Can you help him, this is what he needs?" and then he or she goes and accesses that. But we have a free exchange of information so that we can make sure that client has attended and is getting the support that they need.

Probation Officer

On the contrary, collective voices in support of siting the service within the premises of the probation trust maintain that this location will ensure that the provided service is accessible:

If the service is remote and it's distant and it's not part of your day to day environment, you can forget about it. So from a practical point of view and from my experience as working as a probation officer, if it's here and

people are in your face and they work with you and they don't work in isolation then in reality you're more likely to use that service.

Probation Officer

There are a lot of prisoners released on license so intuitively the probation would be the best place to cite this service because they have to go there, book in for their appointments, if they don't turn up for them then they get recalled.

Offender Health Commissioner

With regards to data protection, the collective voices were unanimous in their agreement that information between service users and the nurses revolving around presenting health needs be kept confidential between both parties but shared with probation officers where it is considered that the clients' health condition could lead to re-offending:

Well obviously if it's health related then it is confidential unless obviously it is a specific health issue that has implications for other people but other than that I think that health issue is something that is confidential providing they're not telling you anything that's linked to offending or anything that they're doing on that line then yeah I think it should be kept confidential.

Probation Officer

If it's mental health, if it's dealing with risk for example someone has a debilitating disease that can be spread we want to know about it for example Ebola, we want to know about it right? HIV, you know these

things here. If it's risk involved then obviously yes if there's a risk but if it's personal health etcetera I don't see why I should know unless that person wants to divulge it to me. But if it's a risk issue yes I think we should know about it.

Probation Officer

Furthermore, it was uncovered in the collective dialogue that considerations revolving around safety could potentially influence the interest expressed by nurses in the role. Accordingly, it was advised that safe guards through training and skill acquisition be put in place to assure the safety of the individual recruited into the role:

Probably a bit of fear really. If you've worked with inmates then obviously you wouldn't have that fear but if you're a nurse out in the world and you've got no experience of inmates, then there would be that kind of bit of fear I should imagine. Because it's the unknown isn't it? You're not going to know the history of why that person has committed an offence. I think anybody who would want to take on this role would not have that fear because they're going to be knowing they're going to be working with ex-criminals anyway. So they probably would be already experienced. You'd have to make sure that there's obviously an alarm system in place. That would be a definite. The nurses would have to be trained at obviously conflict and looking at their own safety.

Acute Trust Nurse

Things like self-defence might be a good idea. Just little things like when I worked at mental health unit just little things like I was taught and I hadn't had the faintest idea before, always be closest to the door. So I would expect although the CPNs would teach you what to look out for if somebody is showing signs of aggression, it would be more the aspects of actually how do you get out of a situation, that sort of thing more training wise. Also looking at the psychiatric part of it but also the physical side of it, how do we get out of a bad situation? That sort of thing.

Community Nurse

Furthermore, participants recommend that the nurses employed to the role undergo short counselling courses which could potentially help them engage with ex-offenders in a person centred way:

I would like possibly a short course counselling course. You see an array of lots of different patients but I think a short counselling course would help you to engage with that offender because you don't come across offenders every single day. And you know you don't know what they've been through in their life and I think there's a six week one or something like that-- I think a short counselling course would go far I think.

Community Nurse

When participants were asked if they felt a particular type of nurse was suited for the role, participants maintained that the role would be ideally suited for a nurse with an urgent care background:

I think you've got to have that kind of background. I think acute medical and the emergency care and urgent care backgrounds I think you do because you pick up on those kind of people. You pick up on a danger sense. I mean you do pick up on danger senses when you're on a ward, a general nurse in a general ward. But in A&E for me personally I would pick up body language, I would pick up eye contact. I'm not saying that another nurse in another speciality wouldn't but we were trained in those aspects, not self-defence but recognising those contributions and what to do next. You do come across them more than what a general nurse would on a ward.

Community Nurse

6.3.5 Collective voices: participants suggestions

This phase of the analysis evidences collective voices suggestions bordering on ensuring that offenders continue to access healthcare on release from prison.

The collective dialogue indicates that it is important that commissioners of healthcare in prison begin to think past the immediate needs of offenders and put in place structures to ensure that their health needs continue to be addressed post prison in the communities to which they will be released into:

So I think the prisons perhaps need to look at doing what CARATs do, the drug support do is make sure that that client is registered with a GP, there's a GP at the other end ready to pick that up and prescribe that

medication. I can understand why they wouldn't release somebody from prison with lots of medication but I think there needs to be somebody to pick them up at the other end when they come out and continue that service.

Probation Officer

I think it would be good for us as providers within the prison to have a single point of contact within the areas that people are being released to, to actually say "We've got these people being released, these are the issues that they've got, these are the appointments or whatever, can you follow that up?" That would be the useful thing to us.

Offender Health Commissioner

It is important to note here that the above suggestion was made in the context of addressing the physical health needs of offenders as services exist to address the mental health and substance misuse health needs of offenders on release as a unique group in need of tailored support. In addition, the collective voices felt that a mentoring service could further benefit service users in the period post licence as such a service could support their presenting needs and mitigate against depending on the probation officer in the period post licence:

I think there are services around that we need to look at about what services they can provide that's not related to their order or their license. That's something for the client and the client alone and nothing to do with us as such. Probation used to have mentors and I think perhaps we need to look at introducing that again, or work in partnership with people in the

community, organisations and partnerships in the community about getting involved with their mentoring scheme. Because what in my opinion we need to do is push people away from probation really so that not everything in their lives revolves around probation.

Probation officer

Probation has always been a statutory intervention at the end of the day based on law. So we do all the work and they're fantastic for the 12 months and after that we just drop them, get rid of them. And the underlying problems haven't necessarily gone away; you dealt with the surface but still underneath there are issues. At the end of supervision if they've got someone they can go to and say "What about this? Where do I go for this? What about that? How do I do this?" perhaps the reoffending rates would drop even further.

Probation Officer

Having mentors could potentially reduce re-offending rates at the post license phase. However, the collective voices maintain that this is not done locally due to the cost implication of such interventions and the fact that the post license phase of an offender is not considered a remit of the probation service:

The reason probation don't probably do it is funding, caseloads and that's not our remit.

Probation Officer

Now if that person is not on probation, how do you assess the risk? If you've started that contact pre then maybe but if they've been working

with them as a probation volunteer and the probation contact ended, does the duty of care fall back to Probation? And you don't know what the current situation with that person who had been in probation is. They could be deteriorating, risk increasing and you're still sending a volunteer in and would not be doing any checks on that. That would be another consideration as to why you don't have that.

Probation LDU Head

Nonetheless, in the commissioning of such a service, it was advised that such a service use as mentors individuals with a prior experience of the criminal justice system:

I think that our client group just like the rest of everybody they like to talk to people who have first hand experience really. And it may be that, that person hasn't been through the system for 10 to 15 years but I would love to see us as a service develop a group of ex-offenders who can engage with our offenders on a level that they can relate to. They might not need to speak to them for three or six months but they also might need to speak to them three or four times a week just to deal with a particular issue.

Probation Officer

Getting them to talk as peers together, so someone will have accessed something and that's how they've done it, they're going to take that on-board a lot better than coming from some stuffy healthcare professional that's never been in prison and doesn't know what it's like to be homeless and all that sort of thing. So that definitely would be a good idea and if you

can get it into that model of assertive peer support where they actually do that assertive linkage then that model in the evidence base works a lot stronger than just an individual healthcare professional doing it.

Criminal Justice Nurse

In addition, the prior experience of these individuals of the criminal justice system could potentially act as a risk limiting factor and a safeguard from being manipulated by the offenders they have been paired with:

For me personally it doesn't work when we've got very, very well meaning volunteers but they can also be manipulated as well because I think we need to be careful about who offender wise we would refer to a mentoring service.

Probation Officer

With regards to meeting offenders in prison prior to release, the silence dialogue indicated that prior to release, offenders would like to have met their probation officers in person in preparation for their re-entry into the community. The collective voices agreed with this and maintained that this was crucial and had the potential to facilitate transition into the community:

I worked in a prison as an Offender Manager and that was the constant theme when I was in, they don't know who their Offender Manager is on the out. And so when I did come back I did say it long and loud to my colleagues "Please get in touch with them because it's really important to them because I've actually been on the other side and I know what it's like for them not to know and then you've got this faceless person who is

making decisions about you ready for your release that you actually don't know.

Probation Officer

I'm an advocate that we need to make strong links anyway with these individuals so that at least we can start the process while they're in custody as opposed to when they come out and I understand starting so cold can obviously be off-putting and they may have a perception that you are aloof from them and that we're just going through the official stuff and we don't sort of see them as a person or we just see them as criminals so to speak.

Probation Officer

However, the collective dialogue indicated that this is not being done due to the pressures imposed by the nature of the role of a probation officer as it currently exists and the cost implication of such contacts:

People feel connected then, they know who you are, they know when they ring they've got an image and how you're going to react. It's a massive part of our job that's been lost because of resource cuts because of restrictions on travel and it's been lost now for probably three to four years? And we know it has an effect. But we're not the ones making that decision.

Probation Officer

We are now in a culture which is target driven and you've got to meet targets and so forth. And the idea of making that sort of continuous link

with the offender is being imposed upon because of other pressures elsewhere. it's unfortunate really for them because it's not because the Officer don't want to, it is because we haven't got the time to make the prison visits anymore as we used to. It's different because you've got as I say such enormous workload pressure.

Probation Officer

It is important to note that a pre-release assessment is usually done before release and where possible probation officers endeavour to meet their cases in person prior to release. However where this visit is unable to occur, standard practice appears to be the writing of a letter at sentencing introducing the probation officer to the offender:

What would happen is that when somebody is initially sentenced we write to somebody and say "We understand you're sentenced, I'm going to be your probation Officer" introduce ourselves. Ask them to keep in touch. And then that level of what contact goes on then depends on how they respond. Because A) there's no point in writing to somebody if they're not writing back, yeah?

Probation Officer

However, due consideration into whether or not the offender can indeed read is not given and consequently begs the question: what happens to offenders who cannot read? With regards to help with GP access, the collective dialogue in alignment with the silence dialogue indicates that probation officers helping offenders to access

GP's in the community is good practice and an issue which probation officers could improve upon through regular and consistent signposting:

We're not support workers. That's not to say it can't be part of what they do but actually if you have an individual presenting with a whole range of issues and they're risky, finding them a GP is probably the last thing on the list. What I do think we should be able to do is to signpost them.

Probation LDU Head

I think that's quite reasonable really. I think everybody needs a GP and very often clients don't have GPs and then they wait until they need a GP and then it's "I've got nowhere to go". We do have a list of GPs and we could be phoning them and helping support the client to phone them and make appointments and get registered.

Probation Officer

However, it was noted that probation officers were not conversant with the rules governing GP registrations and would need to be provided with the requisite information:

I know clients who have been in to register and they can't be registered because they've got no ID and it's a nightmare for clients to try and get registered. It is a bit of a nightmare for them at the moment. And I'm very unclear, so I perhaps need educating about why some people can't register, what is it they need to provide? What are their rights in terms of registering with a GP? Because I'm not fully conversant with that. But many clients say "I've got no ID, they won't register me" so I don't know if

people are obliged to provide ID or not? Are doctors allowed to refuse to register you? What happens if they do refuse? What's the action then? So perhaps we need some education about that do you know what I mean?

Probation Officer

I'd say we need more help in that area as well in terms of accessing the GP's, how we go about it because it's not necessarily clear to us neither. So yeah, we might have the list but if the GP is refusing them it's like what do we then do kind of thing so that would be useful.

Probation Officer

Furthermore, it is important to point out that referral by a probation officer or advocacy on behalf of an offender by a nurse for registration with a GP surgery may unwittingly lead to the stigmatisation of the offender:

If you're liaising with a doctor and you say you're from probation the doctor or the surgery automatically wants to know what the person has done to be on probation. And while in some cases that's appropriate to manage risk and in MAPPA cases sometimes you'll make disclosure to the GP, if the contact didn't come from probation the doctor of the surgery would know nothing about that person and sometimes they don't need to know anything about that person. Knowing that Mr Smith has been referred by probation, is on probation leads you to question what he's done. So it's difficult in terms of maybe we need to signpost people better into how they register but I think there's a downside if we were to do it for

them and it may be that we get into issues with disclosure and that which just don't need to be.

Probation Officer

With regards to an open evening for health issues, the collective voices felt that an open evening around health issues had the potential to not only educate and inform custodial based ex-offenders on accessing health services in the community, but also their case officers as well:

I think an open evening would be absolutely ideal. I think it would be not only helpful to our clients, it would be helpful to staff members as well to be having that baseline information that we can sort of continue to keep reinforcing with people. So yeah.

Probation Officer

However, a worry was the likelihood of such an event not being attended:

Yeah. People on community based sentences, or on license, to attend their statutory appointments is difficult enough. To expect them to turn up to a voluntary appointment I think would be, I mean sorry to be cynical about this but I think that you get very, very few people turning up.

Offender Health Commissioner

It would be down to demands. Because sometimes you put events like that on and the demand isn't very great so they end up falling by the wayside so I mean like an open day or an open afternoon, I don't see why not.

Probation Officer

In addressing the issue of attendance, it was suggested that probation officers be properly briefed on the intent of such an evening in order to ensure that such events are properly sold to the offenders they manage:

I think if as Officers we had as much information as to what the purposes is, who is going to be there, what sort of advice they can give, then we can present it better. I think sometimes we get told "Oh there's these evenings" and then we don't know what the answers are to people that do want to go. So I can see the benefits. I think there might be good attendance if it's sold right.

Probation Officer

We can only encourage them in targeting the clients who probably might be in that situation. Because it's going to be those ones who are going to be inclined to come because others won't really see a need to come. So it would just be encouraging them to come really.

Probation Officer

Participants also maintained that the timing of any such event would have to be carefully considered so as not to unwittingly exclude some service users:

I think clients who work or who have got college commitments or childcare commitments and things, miss out a bit on things that are in the day because they're not able to attend. And I think if you're going to do a session that's going to capture everybody it needs to be in the evening. And traditionally our programs here run from say sort of half past six so that people who have been at work all day or have got primary child care

in the daytime with school and everything else means that they can free some time up after half six.

Probation Officer

Finally, it was advised that such an open evening be delivered in a manner and way which does not exclude high risk offenders:

The issue with having something like that is it's helpful for our lower risk offenders because for them it is around reintegrating them into mainstream community so actually their needs and risks and everything else are much lower, we can see them in groups. To do that for that cohort of offenders is still quite a helpful way forward but my suspicion is that it's the harder to reach groups that we don't get. Yes an open evening is good or sessions around health are good for some groups of offenders, but how do we then capture the ones that don't attend those groups because they don't like working in groups?

Probation LDU Head

6.3.6 Collective voices: uncovered silences

This phase of the analysis evidences the 'Silences' which were uncovered as a consequence of conducting this dialogue with the collective voices. It is important to note here that this study did not set out to investigate these Silences. On the contrary, these Silences emerged overtime from the narratives of these voices as

issues which could potentially mitigate against the continuity in access to healthcare for offenders on release in the community.

The collective dialogue indicated that in addition to their health needs, on release, ex-offenders have considerable structural needs. However, they maintain that help in addressing these needs appear to be limited and predominantly provided through a mechanism in which the probation officer is situated as the facilitator:

They get very little help from the Job Centre, again that's something that we're trying to redress in terms of linking up with the Job Centre because a lot of them will be excluded from benefits for various things or they might have literacy issues and they don't get the assistance they need there so although we're here to run the licences and run the orders very often we end up doing everything else as well to make sure.

Probation Officer

Although it was indicated that in preparation for release, some measures were put in place in prison to ensure that on release some of these structural needs were addressed, the collective dialogue indicates that information on these measures appear to be inconsistent:

I'm not really familiar about what support they do have in prison okay? For example things like housing, whether they have a Housing Officer in the prison who is going to support them when they're ready to be released into accommodations that is sketchy okay? Because we have people who come out of prison and they don't know where they're going to stay, they

have friends that you know? So we as probation Officers out here now have to do the running around, refer them to housing etcetera and so on you know? Which I think needs to be more concrete in prison while they have time, someone as a Housing Officer has time to make sure that there is some kind of accommodations available because they're only going to commit crime again if they have to sofa surf.

Probation Officer

The collective dialogue further indicated that there was a lack of joined up working between prisons, the probation service and primary care. Indicative comments include:

It needs to be more co-ordinated because sometimes the prisoner is doing one thing and then they don't know what the prison has done and then they release the person because there's no information forthcoming from the prison necessarily. I'm not saying that wouldn't necessarily be to us but to the GP of that person if that person has already got a GP then that information should be flowing.

Probation Officer

Now in terms of MAPPA you've got a duty to cooperate as agencies. Which includes health authority or strategic health authority, primary care trust and the NHS Trust. So they all have a duty to cooperate and I'd say we perhaps struggle to get them on board.

Probation Officer

Furthermore, in alignment with the silence dialogue, the collective dialogue indicated that probation officers felt that they were increasingly being overworked:

We go through a bureaucratic process and common sense is sort of gone out of the window and it's about ticking boxes and hitting targets and that's where in my opinion it's all gone wrong. Because it doesn't allow you to develop that sort of rapport with the other person on the other side. Because all of the evidence would suggest that change comes through a therapeutic relationship. We're almost not allowed to do that because when we're answering to our manager it's not about 'Have you made that effective change?' it's 'Have you hit your targets?'

Probation Officer

Practically we've had cases in the team, longer term custody cases and because people have been working above their capacity, the cases have just sat kind of in my name and I've picked up any work that's arisen from those cases but there hasn't been like a constant dialogue or ongoing interaction with those cases. So because of resources they've had the minimum service if that makes sense.

Probation officer

It was also uncovered that offender supervisors were understaffed across the prison establishment. Accordingly, it is to be expected that the supervision provided will be constrained and limited in scope:

Prisons have experienced difficulties with staff, with training, with getting people in the right place. So if you've got an offender supervisor who has

a whole range of individuals to look after, their relationship with each of them is likely to be less. I think there is a model for offender supervision in custody, there are certain minimum standards that they should meet. I think it's recognised that that's been difficult and they haven't done that.

Probation LDU Head

Importantly, the silence dialogue indicated that participants felt that total disclosure to their probation officers even around issues concerning health could unwittingly land them in trouble with the law. This was corroborated in the collective dialogue and suggests the need for a service which is nurse led as opposed to one in which probation officers are equipped with the skills to deliver any proposed intervention:

And maybe they want the advice outside of probation so they don't get judged by their officers or whatever. So I think that would probably be the better way forward rather than treatment.

Probation Officer

Whilst this dialogue uncovered that there is some provision for addressing the mental health and substance misuse needs of offenders on release as a unique group, it was uncovered that services to address their physical health needs as a unique group in need of support is non-existent. The assumption is that offenders on release will access services for their physical health needs through the channels open to other members of society:

There is a gap there which other agencies drug, alcohol, mental health, we have those services that can pick up but anybody who has a physical

health issue is actually falling by the wayside so there is a need for this service I think.

Probation Officer

Clients with physical health needs I found as I say, they've been given the medication in the morning, given a couple of tablets and said "Right there you go, go and see your GP when you're released" and that's not always easy because GPs are very overworked and very often clients can't get an appointment for a long time or they've disengaged with the GP and they're not registered anywhere or they've moved to a different area.

Probation Officer

Furthermore, this disparity is in part due to the fact that there is very little evidence to suggest the implication of poor physical health on re-offending:

And to be fair most of the time a person's physical health doesn't have a direct impact on their risk management and risk to others.

Probation Officer

Although the silence dialogue did not indicate this, it was uncovered in the collective dialogue that there is a need for the family members of offenders to also be provided with support in enabling them to cope with the released offender on release from prison:

Offenders coming out into a family that's been in the community and he's been in jail, you have a wife and you've got a couple of kids and he's in jail. That woman becomes the father and the mother and everything else

and she's going through a lot of stress and depression and hard trials while he's in prison given his meals etcetera. He comes out and comes into the family structure and the children how they'll take him and her etcetera, we're talking about health here. So this partner now needs more support than the actual offender who is coming out because really in prison you should have health taken care of. But the partner who is left out you know there's a need there for her.

Probation Officer

What you need to do is tap into the social network and those significant others that they associate with to bring positive influence so to build the social capital around them to assist them to change their behaviour and change their lifestyle into a more positive way. So I think that is fundamental to the work that should be done. And the family is critically important. And often where family relations have broken down, that can also lead to social isolation and increase the likelihood of reoffending, breaking down in family can also lead to homelessness.

Offender Health Commissioner

Furthermore, it was uncovered that GP surgeries in the area where the study participants were being supervised were refusing to register ex-offenders for reasons such as the lack of a fixed abode or appropriate means of identification. In addition, it was uncovered that probation officers are unable to advocate for ex-offenders who get refused registration due to their lack of information on the stipulated national guidelines in England and Wales governing GP patient registrations:

I know clients who have been in to register and they can't be registered because they've got no ID and it's a nightmare for clients to try and get registered. It is a bit of a nightmare for them at the moment. And I'm very unclear, so I perhaps need educating about why some people can't register, what is it they need to provide? What are their rights in terms of registering with a GP? Because I'm not fully conversant with that. But many clients say "I've got no ID, they won't register me" so I don't know if people are obliged to provide ID or not? Are doctors allowed to refuse to register you? What happens if they do refuse? What's the action then?

Probation Officer

And getting registered with a GP service is quite a difficult task. And I don't always know the answers to that. And I think you need the professionals that know the system of how to deal with that and that will be quite useful really.

Probation Officer

Regarding probation contact with offenders in prison, it was uncovered that the practices of probation officers presuppose that all offenders can read. This is evidenced in their practice of introducing themselves to offenders at sentencing via the means of a letter. This assumption is flawed as there is evidence to suggest that most offenders have below average literacy skill and trouble asking for help (Social Exclusion Unit, 2002). Consequently, the practice of writing letters without thought to whether or not the offender can read unwittingly excludes those offenders who cannot read and supports the need for alternate forms of establishing contact with offenders:

I mean sometimes, I mean we always write to them when they get sentenced, we always send them a letter telling them who their Offender Manager is.

Probation Officer

However, it is important to note here that there are procedures in place to address the communication difficulties posed by offenders with poor literacy skills:

We have skills checkers at the beginning of when a report is done so a basic skills assessment is done at the point that the report is written. Where we know that there is a need in terms of literacy needs, the offender manager has got the ability to email a letter to the offender supervisor and ask them to read it to them, deliver it to them there. I think what we know to happen is the majority of prisoners will get someone else to read that letter to them. What we don't have is anyway of checking that they've read it. So there is an assessment where people have absolutely identified issues that they can't read, if offender managers are aware of that then they can direct it through the offender supervisor.

Probation LDU Head

In the aforementioned context, the bone of contention appears to be to what degree offender manager's investigate the literacy skill of offenders prior to addressing them in writing and where necessary, enlisting the help of offender supervisors towards ensuring that the contents of these letters are conveyed to the offender.

With regards to the privatisation and consequent restructuring of the probation service in England and Wales, It was uncovered that this privatisation has created a situation in which probation officers appear to be uncertain as to the direction of travel of the new services which have emerged:

I think probably XXX and XXX who is the CRC equivalent. Whether they can give you the answers, it's all very much up in the air at the moment unfortunately but they would probably be the best to give you that information.

Probation Officer

Obviously with the split in resource I guess it would have to be an agreement between NPS and CRC about what they would contribute. They can't agree on nothing at the moment.

Probation Officer

Furthermore, it was uncovered that this restructuring could potentially affect how the monitoring of information is collated particularly where such information is tied to an incentive:

If there is no recognition in the performance monitoring that physical health needs may be related to continued offending and if that is not recognised in performance monitoring returns, then I would worry that it would become lost as part of the support services to the individual. And probation officers will only concentrate on those things which are counted and those things which are related to performance and those things which are related to the incentives and the rewards and the pay, not for them

personally but for the organisation. So if there was for example if there was a payment related to a referral and engagement in mental health services, that would concentrate their minds to ask the question, identify the issue and make the referral. If there isn't any form of monitoring or reward or payment related to physical health problems well it would be quite natural not to concentrate on those things.

Offender Health Commissioner

Finally, it was also uncovered that over time, the intent of supervision had gradually changed from a focus on facilitating rehabilitation to one focused on avoiding re-offending:

The role is to address the criminogenic issues that underlie the offending. And I think what's probably got lost in that is that the human relationship is critically important and the skills to engage people is critically important and to build up trust is critically important for people to reveal things to you which can then be helpful in assisting them understand how and why they have offended or may continue to offend..... There used to be a Social Work qualification and they then changed it to a Criminal Justice qualification and the new officers coming through who were not social work trained displayed to me a much more confrontational behaviour towards offenders which led to much more of a breakdown in relationships and confrontation between offenders and officers than were previously being experienced of the officers who had been trained as social workers.

Offender Health Commissioner

7.0. CHAPTER SEVEN – WORKING WITH SILENCES – Research findings

(Silences-Stage 4)

This is the 4th phase of analysis (researcher reflection) which is presented as stage 4 and the final discussion of this study. The discussion presented herein contextualises the findings generated from both the silence and collective dialogue with the initial aims and objectives of the study. This also evidences how the study findings led to the study final outputs which are presented in the ‘planning for silences’ chapter.

7.1 Before release

This section presents the researcher’s interpretation of the findings regarding the offenders’ experience of pre-release support and the consequences of this support on their ability to access healthcare services on release in the community.

The silence dialogue indicated that offenders felt they received good treatment for their health conditions while in prison. The collective dialogue did not corroborate this but indicated that while access to health practitioners in prison was good, the delivery of health interventions in prison was inconsistent and varied from the immediate provision of services to the non-delivery of services. However, what was clear from both dialogues was that even when offenders received treatment for a health condition in prison, the interaction with the health practitioner and the treatment received did not prepare them for ensuring continuity in access to healthcare on release. Furthermore, it was posited that ‘revolving door offenders’ were likely to not complete treatment for a condition diagnosed in prison.

It is posited here that offenders' construction of being properly treated for a health condition while in prison is influenced by the chaotic nature of the lives they lead in the community which is expressed in their consistent inappropriate use of crisis medical services (Eshareturi *et al.* 2014). It is rationalised in this context that this access is what is constructed as 'being properly treated for a health condition' and suggests why the assertion of the silence dialogue that offenders were properly treated for a health condition while in prison was not corroborated by the collective dialogue. The findings of the collective dialogue with regards to access to health practitioners in prison is corroborated by available evidence which indicates that prisoners have a high rate of uptake of health services (Patterson, 2010; Wildeman, 2012) with UK prisoners consulting, on average, three times more often for general care than a demographically equivalent population (Till, Forrester and Exworthy, 2014). This is not surprising as the circumstances surrounding imprisonment promotes access to health practitioners (Plugge *et al.* 2014).

However, an uncovered silence from the narratives of both the collective and silence voices was that the healthcare received was often not equivalent to that which would have been received in the community for similar presenting problems. The ethical principle of justice, translated into clinical terms as equivalence (Exworthy *et al.* 2012), provides an ethical and legal obligation for prisoners to be entitled to and have access to the same level, range and quality of healthcare as that provided to society at large, without discrimination on the grounds of their legal status (United Nations, 1990; Charles and Draper, 2012; Till, Forrester and Exworthy, 2014). Indeed, the Prison Service and the NHS Executive maintain that prisoners should receive equivalent healthcare to that which they would receive in the community, and

that this should not be disrupted by coming into prison, being moved between prisons or being released (Joint Prison Service and National Health Service Executive Working Group, 1999). However, the collective voices indicate that this principle is contradicted and evidenced in the inconsistent and often varied nature in which health services are provided to offenders ranging from immediate provision to the non-delivery of health services.

Furthermore, both the silence and collective voices indicate that access to health practitioners in prison did not prepare offenders for the lack of continuity in access to health services in the community on release. Indeed, available evidence suggests that there is a lack of pre-release preparation aimed at facilitating the continuity in access to healthcare for offenders on release from prison (Sainsbury Centre, 2008; Care Quality Commission and Her Majesty's Inspectorate of Prisons, 2010; Byng *et al.* 2012; Dyer and Biddle, 2013). It is posited here that every contact with a health practitioner in prison needs to be supported with information which could enable the offender to continue to access healthcare on release from prison. This will be particularly useful for 'revolving door offenders' who indicate that while they find the experience of imprisonment unpleasant, they recognise and use imprisonment as a period for the uptake of health interventions (Sainsbury Centre, 2008; Howerton *et al.* 2009).

Regarding offenders' supervisor pre-release support, the silence dialogue indicated that offender supervisors did not provide any pre-release support for offenders towards ensuring that they continue to access healthcare on release from prison. The collective dialogue corroborated this and posited that a cost consequence

explanation could be made for the present status quo. Nonetheless, the collective dialogue indicates that the management provided by offender supervisors was inconsistent, and that offender supervisors were rarely aware of the physical health needs of the offenders on their caseloads. This dialogue further indicated that the data protection act made it difficult for probation officers to obtain information on the health of offenders prior to release. Worryingly, it was also uncovered that the relationship between offender supervisors in prisons and probation officers in the community did not always exist at any level.

The findings of the silence dialogue which maintained that offender supervisors were not providing pre-release support aimed at ensuring that offenders continued to access healthcare on release from prison is corroborated by available evidence. This evidence indicates that despite efforts to facilitate continuity in access to healthcare, the relationship between prison staff and prisoners in English prisons are detached and confrontational with staff being unresponsive and more inclined to punish (Dirkzwager and Kruttschnitt, 2012). The collective dialogue assertion that a cost-consequence case can be made for the lack of pre-release support revolving around health is corroborated by available evidence which indicates that the present economic climate in the UK has necessitated a state of play within the prison establishment where the principles underpinning interventions are grounded in the doctrine of making prisons cheaper (Allen, 2013). Thus, it is not surprising that this study uncovered a lack of pre-release support oriented towards ensuring that offender supervisors prepared supervisees for accessing healthcare on release from prison.

Commenting on the relationship between offender supervisors and probation officers, Robinson (2005) acknowledges that the trend in pre and post release supervision is one oriented towards a fragmented style of offender management whereby staff increasingly occupy specialist roles, and offenders encounter a variety of staff over the course of supervision, often being conceived as 'portable entities' in which staff are obliged to engage in a 'pass-the-parcel' style of supervision. This corroborates the worrying finding of the collective dialogue which indicates that the relationship between offender supervisors and probation officers did not always exist on any level. With regards to the assertion of the collective voices that the data protection act made it difficult for probation officers to obtain information on the health of offenders prior to release, available evidence supports this and acknowledges that this situation stems from the fear of breaching professional codes of practice and the possibility of litigation for such violations (Senior *et al.* 2012). Furthermore, a major barrier to information sharing is the lack of clarity and professional understanding of The Data Protection Act (Thomas and Walport, 2008).

However, while health service staff often sought and successfully received service user information from criminal justice agencies, on the contrary, criminal justice staff only appear to seek basic health and risk-related information about service users from the NHS which is rarely received, and when received, not timely (Lennox *et al.* 2012). It is important to note that although guidance has been produced on the application of The Data Protection Act in relation to the use and disclosure of health data (Department of Health, 2002), such guidance appear not to have filtered down to frontline staff as can be deduced from the narrative of the collective voices. This speaks for the need of training to be delivered to members of the criminal justice system bordering on The Data Protection Act and health disclosure. This also

underlies the need for interagency collaboration and timely information sharing between the criminal justice system and the National Health Service.

7.2 On release

This section presents the researcher's interpretation of the findings regarding the offenders' experience of on-release support and the consequence of this on their ability to access health services in the community. It is important to note here that as conveyed in both dialogues, the on-release period was considered to begin in the immediate weeks preceding release.

The silence dialogue indicates that offenders had no on-release support aimed at preparing them for accessing health services in the community. It is indicative to note that offenders, through the silence dialogue, consistently constructed 'day release' as equating to having received on-release support. However, the narrative of the collective voices contradicted those of the silent voices on this issue. The collective voices maintain that some prisons provide on-release information to enable individuals to continue to access healthcare in the community but that this practice is not statutory and varies across the prison establishment.

The consistent identification of day release as on-release support suggests that tailored support was not received in preparing offenders on-release for accessing health services in the community. The intent of on-release support has traditionally focused on addressing the pressing practical problems faced by offenders such as housing and income and accordingly, interventions have been driven towards addressing their structural needs. This is driven by a recognition that unresolved

practical problems are closely related with reoffending (Maguire and Raynor, 2006). In this context, the main objective of resettlement interventions across the prison establishment appears to be crime reduction (Moore, 2012). Consequently, the lack of on-release support oriented towards accessing healthcare in the community supports the assertion of the silent voices that on-release support was received for addressing their practical structural needs but that this was not replicated in the context of health. This suggests that the focus within the prison system is not on the health of offenders as this conflicts with the ideology of security and discipline (Reeder 1991).

The finding of the collective dialogue indicating that it is not statutory for prisons to provide on-release information to enable offenders to continue to access healthcare in the community is corroborated by available evidence. Treatment for conditions diagnosed in prison currently varies considerably (Forrester *et al.* 2013) with on-release preparation for accessing care not dependent on any clinical guidance (NICE, 2014). Moreover, the provision of on-release support is further compromised by the overcrowded nature of UK prisons which mitigates against the application of good practices across the prison establishment (Sainsbury, 2008; Prison Reform Trust, 2014). Indeed, the very notion of on-release support is challenged by the practice of moving offenders with little notice between prison wings and across prisons to manage overcrowding and the consequent risks which this triggers (Prison Reform Trust, 2014). From the narratives of both the silent and collective voices, it is obvious that the importance of working with offenders prior to release and on-release cannot be overemphasised as this has the potential to enable the offender to prepare and plan for their continuity in access to health services in the community. However, it is clear that in practice this does not happen, and from the evidence

collated herein, it is safe to posit that offenders do not feel that they get enough support to plan for what will happen after they are released with regards to their health.

Regarding access to a GP, It was established in both sets of dialogue that the on-release preparation for offenders did not enquire, as a matter of procedure, whether an individual was registered with a GP or had the agency to self-register on release. The dialogues indicate that the lack of a fixed abode and appropriate means of identifying self mitigated against offenders being registered with GP's on release. However where offenders had been signposted to be registered with a GP, it was not always followed up by the probation officer that indeed this had been done. Furthermore, both dialogues indicated that there are no clear pathways for the transfer of patient clinical records between prison and primary care.

The findings indicating that on-release preparation did not routinely include enquiry as to whether an individual was registered with a GP or had the agency to self-register is supported by available evidence. The evidence available indicates that although we know that around half of prisoners had no GP before they came into custody (SEU, 2002), preparation for access to a GP on-release does occur, but not on a regular basis nor for all offenders across the prison establishment (Byng *et al.* 2012). This preparation predominantly entails prison healthcare contacting the offender's GP with some discharge information. However, a study looking at the continuity in access to healthcare for offenders indicates that communication between prison and community GPs is almost non-existent as no records that were recorded as sent by the prison were found in the GP records (Byng *et al.* 2012).

Registering offenders with a GP on release should happen routinely for all offenders and the lack thereof contravenes the prison service order on the continuity in access to healthcare (HM Prison Service, 2006). This order instructs that prison healthcare service must help offenders register with a GP in the community where it is uncovered that an offender is not presently registered with a GP. However, it is important to note that many prisoners are released from court sometimes unexpectedly which potentially mitigates against such support as their release may not have been predictable.

Homelessness exacerbates offenders' poor health in the community and is a barrier to accessing support services such as registering with a GP (SEU, 2002). This substantiates the findings of both dialogues that the lack of a fixed abode mitigates against offenders getting registered with GP's in the community. The evidence also suggests that the lack of an appropriate means of identifying self on release also contributes against registering with a GP (Lang *et al.* 2014). This supports the findings of both dialogues which indicates that ex-offenders were getting refused registration with GP surgeries due to the lack of identification which the surgeries felt was appropriate. The NHS Counter Fraud service in their guidance to GP practices on GP patient registration fraud recommend that it is important to ask all new patients to provide identification, preferably one item of photo identification along with one document containing the patient's address (NHS Counter Fraud Service, 2014). Due to the chaotic nature of offenders' lives on release, many offenders are unable to provide these and are consequently denied registration on this basis (Lang *et al.* 2014).

However, denying potential patients registration on this basis contravenes the rule governing registration with GP surgeries in England and Wales (NHS London, 2013).

GP Practices are not obliged to ask patients for official documentation in order to prove identification or proof of residence and there is no requirement in the regulations for them to do so (NHS London, 2013). NHS England expects practices to register people who are homeless, with no fixed abode, or those legitimately unable to provide documentation living within their catchment area who wish to register with them (NHS London, 2013). Accordingly, homeless patients are entitled to register with a GP using a temporary address which may be a friend's address or a day centre. The surgery may also use the practice address to register them (NHS London, 2013). The practice of denying offenders registration on both aforementioned basis suggests that a nurse led service in which nurses can advocate for offenders could potentially ensure that offenders' chaotic lifestyles do not preclude them from access to primary care in the community.

The findings indicating that after sign posting an offender to be registered with a GP, probation officers did not always check to ensure that registration was indeed achieved is corroborated by available evidence. This evidence indicates that due to the sheer number of people requiring probation services, public protection requirements now dominates the work of probation, while resettlement, rehabilitation, and linking offenders with services to address their health and social care have moved out of focus (HM Inspectorate of Prisons, 2007). The imbalance between public protection, rehabilitation and continuity in access to healthcare is in part a result of the outcome measures such as reoffending rates and breach of licences which are now being used to measure the success of the criminal justice system (NOMS, 2005).

In support of the assertion made by both dialogues that there are no clear pathways for the transfer of patient clinical records between prison and primary care, the

evidence available indicates that indeed this is the case, and that, health records often do not follow offenders in and out of custody (Sainsbury, 2008; Lennox *et al.* 2012). The Bradley Review and subsequent strategy for offender healthcare, Improving Health, Supporting Justice both highlight the importance of information sharing between the NHS and CJS (Bradley, 2009; Department of Health, 2009). However, health and criminal justice agencies have competing organizational aims which can lead to clashes of priorities and create barriers to effective information sharing (Lennox *et al.* 2012). Moreover, different staff groups have specific professional codes of conduct to abide by (e.g. British Medical Association, Nursing and Midwifery Council), the observance of which may not be viewed by criminal justice colleagues as conducive to the ethos of punishment (Lennox *et al.* 2012). This clearly typifies the dilemma associated with reconciling punishment with rehabilitation and underpins the tension inherent in providing healthcare in a criminal justice setting.

Consequently, transfer of patient clinical record between prison and primary care is impeded by a lack of training surrounding disclosure and confidentiality issues, a lack of information sharing between and within agencies, ineffective and inadequate information management, incompatible computer systems and restrictions due to data protection requirements (Dale, Rosenberg and Green, 2008; Morgan, Donovan and Lingham, 2010; Siva, 2010). Although it is acknowledged that sharing service user information between agencies carries both benefits and risks (Thomas and Walport, 2008), it has concurrently been widely acknowledged that appropriate and timely information sharing can lead to better health outcomes for offenders on release in the community (Bradley, 2009; Senior *et al.* 2012). Accordingly, it is posited herein that this lack of a clear pathway for the transfer of patient clinical

records between prison and primary care suggest that there is a need for the commissioners of both prison and primary healthcare to collaborate in creating an IT system which seamlessly interphases between both settings. Such a system should ideally contain information about offenders' physical and mental health, as well as a history of service contact.

7.3 Post release

This section presents the findings regarding the issues supporting and mitigating against the engagement of offenders with health services in the community.

The collective and silence dialogues both indicate that family support is crucial and helpful in enabling offenders to resettle back into society as this support helps offenders structurally re-integrate back into society on the one hand and on the other hand helps them navigate and access health services post release. Furthermore, the silence dialogue indicates that family support is crucial to avoiding re-offending and that the fear of disappointing ones family is essential to desistance from crime post release. Interestingly, both voices noted that a huge proportion of offenders do not have a network of family support and posited that in these offenders, the benefits to be accrued from having a supportive family could be achieved from the supervision received if this was personalised and commenced before the offender left prison.

The evidence available supports the finding of both dialogues and maintains that the family is a major source of support for offenders post release (Martinez, 2006; Miller, Copeland and Sullivan, 2014). Considering the fact that prison sentences have on average become shorter, and thus, markedly more people are being released with

more serious needs and with less assistance from rehabilitation services (Petersilia, 2002, 2003), the importance of the family in helping the offender reintegrate cannot be understated and thus qualifies the assertion of both voices that family support is crucial and helpful in enabling offenders resettle back into society. In addition to the structural gains to be achieved by an offender from a supportive family, available evidence indicates that the support of an offender's family also has the potential to fuel desistance from crime post release (Shapiro and Schwartz, 2001; Petersilia, 2003). This is further supported by a study which analysed former prisoners' perceptions of family support (Nelson, Dees and Allen, 1999). This study indicated that offenders with supportive families were most likely to desist from crime compared to offenders with limited or no family support post release, and that, self-defined family support was the strongest predictor of individual desistance (Nelson, Dees and Allen, 1999).

Petersilia (2003) posits that if a former prisoner does not have family support, the probability of remaining crime-free in the community is almost certainly decreased. Both dialogues reinforce this assertion, yet, maintain that the supervision received could guard against this if it was personalised and commenced before the offender left prison. Available evidence corroborates this and indicates that the most effective post release supervision is one which is person centred and welfarist in orientation (Canton, 2013). Such a model is not only effective in the terms that probation sets for itself, but is also modelled on respecting ethical entitlements (Canton, 2013). In addition, available evidence also indicates that supervision which commences prior to release gives offenders a sense of direction, order and shape (NOMS, 2005).

Regarding health management post release, the dialogue of the silent voices indicates that offenders construct the value of the health services received in the

community on the timeliness of delivered interventions. However, on the aforementioned issue, the collective dialogue indicates that there exists a disparity between services which address the physical health needs of offenders and those which address their mental and substance misuse health needs with the practice of probation officers skewed in favour of addressing these at the expense of physical health. The collective dialogue further indicates that the practice of moving prisoners across the country to accommodate risk creates a situation in which Clinical Care Groups (CCGs) become unwilling to accept financial responsibility for offenders on release from prison and unwittingly leads to a situation which prevents offenders from accessing health services post release.

The construction of received interventions on the timeliness in which these were delivered is corroborated by available evidence which indicates that although power imbalance does affect offenders involvement with healthcare in prisons (Cowman and Walsh, 2013), a key criteria which offenders use in valuing health services is on the promptness in accessing care (Condon *et al.* 2007; Plugge, Douglas and Fitzpatrick, 2008). This was not corroborated by the collective dialogue and accordingly may suggest a disjoint of opinions. Indeed, we know that gauging patient satisfaction in healthcare is problematic and that when patients are asked about health service quality, they are more likely to focus on perceived shortcomings than positive aspects (Coulter, 2006). Moreover, it is important to note that delay in accessing health services in the community is not an issue specific to the offending population but a challenge presently plaguing the delivery of health services across the National Health Service (Majeed, 2013; Smith, 2014).

The assertion of the collective dialogue that there is a disparity between services which address the physical health needs of offenders and those which address their

mental health and substance misuse needs is corroborated by available evidence. Attempts to improve offender health both in and out of prison is focused on offender mental health, which reflects priorities in terms of the size of the prison population with mental health problems, links with reoffending and protecting the public (HM Government and Department of Health, 2011). This has meant that the development of physical health pathways, chronic or acute, and often co-morbid with mental health issues, has been neglected (Dyer and Biddle, 2013). It is therefore logical to expect the health practice of probation officers to be aligned with tackling the mental and substance misuse health needs of offenders at the expense of physical health due to the strong association between reoffending, mental health and substance misuse (Denney, Brooker and Sirdifield, 2014). It is clear from the narrative of both voices that the prison health strategy in England and Wales has a strong mental health emphasis, following on from the Bradley report (Bradley Review, 2009). Nonetheless, whilst it is acknowledged that the psychological wellbeing of offenders is of importance, it is posited herein that addressing this should be done in a manner and way which concurrently recognises and addresses the physical health needs of offenders as well.

The assertion of the collective dialogue that the movement of prisoners to accommodate risk creates a situation in which Clinical Care Groups become unwilling to accept financial responsibility for offenders on release from prison is not substantiated by available evidence. The evidence available indicates that in certain instances, care coordinators are reluctant to continue responsibility for their clients when they go into prison which is most likely to occur if clients become located in a prison a long distance from their home and where their care coordinator is based (Durcan, 2008, Sainsbury 2008). It is important to note here that available evidence

contextualises this issue to the pre-release phase of the offender journey. Accordingly, the evidence does not suggest that on-release, clinical care commissioning groups were refusing to provide care for released offenders in the community. On the contrary, on-release, ex-offenders requiring a health service to be provided by the CCG in the area where they are located are not identified or classed as offenders or ex-offenders. As such, this study found that in spite of their prior imprisonment status, ex-offenders requiring care to be provided by a clinical care commissioning group in the community are provided the required service through the normal pathways which exist for every member of the community.

With regards to supervision on release, the voices in the silent dialogue indicate that offenders found being supervised to be hugely beneficial in terms of reintegrating and accessing both health and structural services in the community. However, it was noted that these voices felt that on disengagement from the probation service, relocating from their present environment and being employed were factors they considered crucial in avoidance of reoffending.

The benefits of being supervised by the probation service cannot be underestimated and is supported by available evidence which indicates that in addition to its cost saving alternative to imprisonment, supervision potentially makes the community safer and the lives of offenders better (House of Commons Justice Committee, 2011). Indeed, supervision improves the lives of offenders through the signposting and advocacy roles played by probation officers who provide access to health services, benefits, housing, employment and training (McMahon, 2013). The findings of the silent dialogue which indicate that employment and relocating are crucial to avoiding reoffending is corroborated by available evidence. Although very few people on leaving prison will have employment on-release (Durcan, 2012), the evidence is

conclusive and suggests that one of the most effective ways of preventing reoffending and improving the life chances of an offender is through achieving and maintaining employment (Durcan, 2012). In like manner, the evidence is clear and suggests that an offender's environment could influence their ability to stay crime free in the community (Swartz, 2011). This consequently supports the silent voices assertion bordering on their perception of the need to relocate in order to stay crime free.

7.4 Suggestions for a nurse led service

This section presents the findings regarding participants views concerning how a nurse led service could act as an intervention for addressing the health needs of offenders post-release. During both dialogues participants alluded to how they would like the issues addressed. Some of these suggestions are raised here as part of the findings towards evidencing the source of the recommendations which are presented in Chapter Eight.

7.4.1 Suggestions from silence dialogue

The silence dialogue indicates that a nurse led service could bridge the health re-entry gap of offenders and enable them to continue to access health services post release from prison if such a service was easily accessible. These voices felt that the probation service would be ideal for siting such a service and they would like the service to be provided as either an appointment or drop in service. These voices also advise that the nurse led service operate on an advisory and sign posting basis; and be modelled on the established principles of data protection in the UK, only sharing

information with the CJS in situations where the health circumstance of the client could constitute a risk to the client or public.

It is indicative to note that although the voices in the silent dialogue unanimously agree that a nurse led service could facilitate access to health services on release, these voices felt that the usefulness of such a service would be dependent on the accessibility of the service to offenders. Accordingly, it is important that any nurse led service for offenders consider the manner and way offenders are likely to access the service as a key feature during the design phase of the service. This design phase must actively seek the views of offenders. The assertion of the silent voices that the probation trust would be ideal for the location of a nurse led service is predicated on the fact that it is unlikely that offenders being supervised at a probation trust would be unable to locate the premises of the probation trust. Furthermore, the provision of a nurse led service at the premises of a probation trust ties into the government's recent rehabilitation revolution which seeks to not only rehabilitate the offender, but also address their structural and health needs while in contact with the CJS (Denney, Brooker and Sirdifield, 2014).

The suggestion of the silence dialogue that the nurse led service be designed as either an appointment or drop in service is indicative of a good grasp of the silent voices understanding of the nature of offenders struggles post release. This suggestion is aligned to the chaotic lives offenders lead post release and is aimed at ensuring that offenders do not become unwittingly excluded from the service due to rigid accessibility criteria. Having the service run on both formats will ensure that the service is constructively aligned to the lived realities of offenders' lives on release.

The suggestion of these voices that the provided service operate as an advisory and sign posting service is crucial. This could potentially guard against the danger of compromising the resilience which the supervisory process is designed to instil as service users will be required to engage with the services they have been referred to in person. Moreover, this will ensure that no harm is unwittingly done through the provision of the service as on termination of supervision, custodial based offenders will have developed the agency to access primary care community based services themselves. However, in the provision of the service on an advisory and signposting basis, it is important to note that this could potentially lead to conflict between the patient and the primary care provider, and stigmatisation of the patient by the primary care provider. Accordingly, nurses employed in this role will have to be aware of this, tailoring their practice towards ensuring that this does not happen.

The silent voices further suggest that health information to be disclosed to the nursing practitioner be modelled on the established principles of data protection, only sharing information with the CJS in situations where the health circumstance of the offender could constitute a risk to the client or public. This speaks for the need to adopt a joint written agreement between the health provider and the probation trust to inform and guide the information sharing procedure of the service. However, it is important that all service users be made aware of this information sharing policy on their first contact with the service.

7.4.2 Suggestions from collective dialogue

The collective voices indicate that a nurse led service can facilitate access to primary care and create a situation in which custodial based offenders can immediately seek

advice on their health in response to a health need. This dialogue also occasionally constructed the service as a means of supervision. Concerns were also raised bordering on the need for the service, public perception of such a service, and the potential for such a service to fuel dependence on the probation trust. This dialogue also questioned the rationale behind having a nurse lead the service in the context of the present economic climate, positing on the contrary that the proposed intervention could be delivered by a health support worker or an administrative staff seconded from the NHS to carry out the role. Due to the present restructuring of the probation service, collective voices maintained that it was crucial that the proposed nurse led service be aligned to the strategic objectives and business plans of the new emerging services. Furthermore, some voices in the collective dialogue suggest that the service would be most effective if the nurses employed in the role established contact with the offenders prior to release. The collective voices also suggest that the individual employed in the role must be conversant with the primary care services which exist in the community and the referral pathways into these services.

Regarding the operational details of a nurse led service, the collective dialogue maintain an alignment with the silence dialogue that any provided service would have to operate as either a drop-in service, appointment service, or jointly as an appointment and drop-in service. It is important to note that the collective voices were unanimous in maintaining that the timing of such a service irrespective of the format in which it is to be provided would also have to be flexible. Participants felt that the provision of the service as an advisory and not a treatment service was in line with the ethos of not fuelling dependence on the probation trust and not duplicating existing services which already exist in the community. Yet, other voices

in this dialogue argued on the contrary and felt that adding a treatment component to the service was worth considering as offenders who may use the service may only have the contact with the nurse as their only contact with a medical practitioner due to their chaotic lifestyles.

Although the silence dialogue indicated that offenders would like to see a nurse-led service sited within the premises of the probation trust, the collective voices were not unanimous in agreement on this. Those voices against siting the service on site indicated that while it may be beneficial to have the service sited in the probation trust, doing this could fuel the dependence of offenders on the probation trust when indeed their supervision is aimed at imbuing them with resilience and the agency to integrate smoothly into the community. On the contrary, collective voices in support of siting the service within the premises of the probation trust maintain that locating it on site will ensure that the provided service is taken up. The collective voices were unanimous in their agreement that information between service users and the nurses revolving around presenting health needs be kept confidential between both parties but shared with probation officers where it is considered that the clients' health condition could lead to re-offending. In addition, it was uncovered in the collective dialogue that considerations revolving around safety could potentially influence the interest expressed by nurses in the role. When participants were asked if they felt a particular type of nurse was suited for the role, participants maintained that the role would be ideally suited for a nurse with an urgent care background.

The narratives of the collective voices corroborate the findings of the silent dialogue which indicates that a nurse led service can improve the health outcomes of

offenders on release in the community. This suggests that a nurse led service could facilitate continuity in access to healthcare on release from prison while concurrently addressing the presenting health needs of offenders in the community. However, it was uncovered that the narrative of the collective dialogue constructed the service as a means of supervision. This should not be done as modelling the proposed nurse led service as a means of supervision is counterintuitive and contradictory to the principles of healthcare provision. However, the narratives of members of the collective voices indicate that this suggestion is based on the increased work pressures presently being encountered by probation officers. The concerns bordering on the need for the service, public perception of such a service, and the potential for such a service to fuel dependence on the probation trust, suggests that there is a need for an economic case to be made in advising commissioners on the need for a nurse led service. This case should evidence the poor health status of offenders on release from prison and build on the potential cost savings to be had as a consequence of the appropriate use of primary care services by custodial community based offenders.

Collective voices narrative questioning the rationale behind having a nurse lead the service in the context of the present economic climate, suggest that an economic case be made to justify the role to be performed by the nurse. This should build on the knowledge base and expertise which nurses already possess as a consequence of their training and practice which guarantees that they do not need to be trained for the role. It is important to note here that employing a non-clinician to the role could potentially expose the service to a situation in which clinicians in both the community

and prisons may not want to engage or discuss the clinical needs of service users, citing clinical incompetence as an excuse in justification.

Due to the present restructuring of the probation service, the suggestion of the collective voices that the proposed nurse led service be aligned to the strategic objectives and business plans of the new emerging services is hereby supported. Doing this could potentially ensure that the service is bought into by those responsible for commissioning offender health services within the CJS. While the intent behind the suggestion of the collective voices on nurses establishing contact with offenders prior to release is informed by the need to ensure continuity in access to healthcare on release from prison, it would be almost impossible for nurses employed in the role to do this due to the sheer volume of offenders which the nurse would potentially have to meet. Accordingly, this suggests the need for the nurse employed in the role to establish direct links with all the local prisons in the area. This is cost-effective to physically commuting into prisons and could potentially facilitate the transfer of patient clinical information between prison and primary care by ensuring that where nurses fax request for notes from prisons, it will be acted upon quickly and be seen as a priority. The suggestion by the collective voices that the nurses employed in the role be conversant with the primary care services which exist in the community speaks for the need of the nurses employed in this role to develop links in the community and be proactive in understanding the referral pathways accompanying the health services which exist within the service area.

The suggestion of the collective dialogue that any provided service would have to operate as either a drop-in service, appointment service, or jointly as an appointment

and drop-in service mirrors that of the silent dialogue. This agreement suggests the need for careful thought to be given into the adopted format of the service so as not to unwittingly exclude potential service users. The collective voices assertion on the flexibility of the timing of such a service is underpinned by the chaotic nature of offenders lives post release and speaks for the need to have a flexible service. Although the collective dialogue corroborated the silence dialogue assertion which indicated that having the service structured as an advisory service would imbibe offenders with the agency to navigate health services independently, this dialogue also maintained that the addition of a treatment component was worth considering as offenders who may use the service may only have the contact with the nurse as their only contact with a medical practitioner due to their chaotic lifestyle. This suggestion was not corroborated by the silent voices. Nonetheless, it is advised that the nurse led service be provided as an advisory and not a treatment service as a treatment service could unwittingly mitigate against the agency which the supervisory process is designed to imbibe in the offender. In addition, consideration of a treatment component must be accompanied by careful thought into addressing issues such as infection control which is associated with the provision of healthcare in a non-healthcare environment. Moreover, it is hereby acknowledged that a treatment component would merely replicate existing community services such as walk in centres.

The concerns expressed by some voices in the collective dialogue against siting the nurse led service within the premises of the probation trust is justified as this could potentially create a situation in which offenders become dependent on the nurse led service just because it is located within a building where they have to be supervised on a regular basis. Although this is acknowledged, siting the service outside the

premises of the probation trust may mean that offenders do not access it for fear of the stigma associated with being labelled as a consequence of accessing a service designed exclusively for offenders. Moreover, the provision of the service within the premises of the probation trust potentially ensures that offenders can access the service at will. Indeed, in this context, it is important to reiterate as previously noted that the narrative of the silence voices indicates that a nurse led service could bridge the health re-entry gap of offenders and enable them to continue to access health services post release from prison if such a service was 'easily accessible'.

The collective dialogue also mirrors the finding of the silent dialogue on data protection which speaks of the need for the provided service to build on the established principles of data protection which govern the clinician-patient relationship in the UK. This dialogue also maintains that considerations revolving around safety could potentially influence the interest expressed by nurses in the role. Accordingly, it is advised that safe guards through training and skill acquisition be put in place to assure the safety of the individual recruited to the role. The collective dialogue further indicates that the ideal nurse for the role will be one with an urgent care background. The narrative of participants indicate that urgent care nurses regularly encounter offenders use medical services in a crisis led way and thus, will come into the role equipped with a working knowledge of caring for offenders in the community. Although it is acknowledged that a nurse with an urgent care background may be conversant with caring for offenders in the community, it is posited herein that this should not constitute a requirement for recruitment into the role. Although, this may be desirable, it is posited that knowledge of the services which exist in the community and the referral pathways into these services be prioritised as more important.

7.5 Further service related suggestions

This section presents the additional factors which participants suggest could be instrumental to facilitating the continuity in access to healthcare for offenders on release from prison.

7.5.1 Support worker

Participants in the silence dialogue maintained that they would like to see a 'life support worker' who offenders on release and at the conclusion of their supervision could have a chat with around their presenting needs on an informal basis. They suggest that such a role should be taken up by an ex-offender. The collective dialogue agreed with this and constructed the role as one ideally suited for a mentor.

The provision of mentors could benefit offenders in the period post-license, as such a role could support offenders' presenting needs and mitigate against depending on the probation officer in the period post licence. Nonetheless, this suggestion is limited by the cost implication of the provision of such an intervention and the fact that the post license phase of an offender is not considered a remit of the probation service. However, the evidence is clear and suggests that offenders continue to have numerous health and structural problems at the end of supervision (Howerton *et al.* 2009; Byng *et al.* 2012). This underlies the importance of having probation providers explore the provision of mentoring schemes to provide support for offenders in the immediate weeks following the end of supervision. This will ensure that at the end of supervision, support is received from individuals who are not likely to entice the newly released offender into reoffending. However, in the provision of such a scheme, careful thought must be given to the financial, legal and human cost which

will be incurred in the provision of such a scheme. Such a scheme could be modelled on the peer led support provided by St Giles Trust (St Giles Trust, 2015).

In doing this, it is important to use as mentors individuals with a prior experience of the criminal justice system. This will ensure that mentoring is provided by individuals with first-hand knowledge of the experience of imprisonment and the challenges associated with reintegrating into society on release from prison. In mitigating against the cost consequence of this, a viable alternative could be probation trusts liaising and working in partnership with organisations in the community towards getting involved in their various mentoring schemes. This will ensure that services which are already available at a local level are tapped into, thus, ensuring cost savings which otherwise will be incurred if such a service was to be provided by the probation service. This could also work on the basis of collating the services which presently exist locally and at the end of license, referring individuals on to these services.

7.5.2 Probation support

The narratives of the silence dialogue indicate that offenders would like probation officers to meet them in person in prison prior to release, provide pastoral support in which officers use personal anecdotes such as their own experiences to convey meaning, and help them register with a GP on release. The collective voices support the idea of meeting offenders in prison prior to release and indicate that this has the potential to facilitate transition into the community. It is acknowledged that the cost implication of doing this constitutes a constraint to the practice application of this. However where possible, it is advised that probation officers endeavour to meet their

licencees in prison prior to release in order to ensure that these individuals understand that their role is not one which is oriented towards punishment but one which is focused on support aimed at enabling them avoid circumstances which may lead to re-offending. This will ensure that a relationship is built prior to getting released and the apprehension which governs the first encounter with the probation officer on release is addressed.

The collective voices did not address the suggestion of the silence dialogue regarding the provision of pastoral support. However, the narratives of the silent voices indicate that the supervision received at times felt 'superficial'. These narratives constructed superficial supervision as one in which the probation officer did not use personal anecdotes to inform given advice. While using personal anecdotes to inform provided advice may be useful, this is not necessary for effective supervision to occur. Available evidence indicates that effective supervision is one which is person centred and tailored to meet the presenting needs of the supervisee (Canton, 2013). The collective dialogue indicated that the request of members of the silence dialogue concerning probation officers helping them to access GP's in the community was reasonable and an issue which probation officers could improve upon through regular and consistent signposting. However, it was noted that probation officers were not conversant with the rules governing GP registrations and will need to be provided with the requisite information to enable them to appropriately sign post offenders and advocate effectively for offenders who are denied registration.

7.5.3 Open evening

The silent voices indicated that an open evening for health issues could potentially help offenders continue to access healthcare on release. The collective voices corroborated this positing that such an evening had the potential to not only educate and inform custodial based offenders on accessing health services in the community, but also their case officers as well. However, a worry was the likelihood of such an evening not being attended and delivered in a way which could potentially exclude some offenders such as those in employment, with child caring responsibilities or categorised as high risk who may have to attend rehabilitative courses in the day.

In providing an open evening, it is advised therefore that on the one hand, probation officers be properly briefed on the intent of such an evening in order to ensure that such events are properly advertised to the offenders they manage. On the other hand, it is also necessary that the timing of such an event be carefully considered so as not to unwittingly exclude service users. Alternating the timing of such events may be a more inclusive approach overall.

7.5.4 Prison healthcare

The collective dialogue indicates that it is important that commissioners of healthcare in prison begin to think past the immediate needs of offenders and put in place structures to ensure that the health needs of offenders continue to be addressed post prison in the communities to which they will be released. The silent dialogue did not address this. However, it is important to note here that this suggestion was made in the context of addressing the physical health needs of offenders as services exist to address the mental and substance misuse health needs of offenders in the community as a unique group in need of support. This underlies the need for

evidence which clearly conveys the link between physical health and re-offending. While there is an abundance of research illustrating the link between mental health and substance misuse on offending, this does not translate to physical health and consequently affects the political construction of offender health with regards to areas of need post release (Eshareturi *et al.* 2015).

7.6 Uncovered Silences

This phase of the analysis evidences the ‘silences’ which were uncovered as a consequence of conducting this study. This study did not set out to investigate these silences; on the contrary, these silences emerged overtime as issues which could potentially impact on the continuity in access to healthcare for offenders on release in the community.

7.6.1 Structural support and joined up working

The silence dialogue indicated that access to a benefit advisor on release could facilitate re-entry on a structural level and posit that such support be provided within the premises of the probation trust. The narrative of the collective voices corroborated this and indicated that a benefit and jobs advisor does indeed come into the probation trust to offer advice and relevant support. However, the narratives of the silent voices suggest that not all offenders who are being supervised locally are aware of this service. This speaks for the need to disseminate the services available at the probation trust widely. Accordingly, it is advised that the probation officer explains the range of services accessible to the offender on first contact in the community on release from prison.

It was also uncovered in the collective dialogue that there appeared to be a certain level of disquiet about the help received by offenders being provided through a mechanism in which the probation officer is situated as the facilitator. This is indicative of the work pressures presently being encountered by probation officers as advice and sign posting is a fundamental aspect of their role (NOMS, 2005). The collective voices further indicate that there are no clear lines for communicating the help received in prison by an offender towards addressing their structural needs on release. The narratives of both dialogues further indicate that this state of affairs is also applicable to health and indicates that there is a lack of joined up working between the health department in prison, probation and primary health providers in the community. This suggests the need for clear and regular communication between an offender's supervisor in prison and the offender manager in the community bothering on the structural support an offender might need on release and clear lines of communication between prison healthcare and offender managers regarding an offender's health and consequent potential health need on release.

7.6.2 Restructuring of the probation service

The silence dialogue indicates that probation officers are being overworked and thus not providing supervision which is person centred. This was corroborated by the collective dialogue which indicated that probation officers felt that they were increasingly being overworked. It is important to note that the narratives of both voices implicate this state of affairs on the restructuring of the probation service. The outcomes of a conference organised by the Westminster Legal Policy Forum entitled 'Probation in England and Wales - assessing the impact of the Transforming Rehabilitation Programme' indicated that indeed the restructuring of the probation

service has, to date, mainly been about privatisation and has resulted in a poorer service (Westminster Legal Policy Forum, 2015).

Furthermore the narrative of the collective voices indicates that the restructuring of the probation service has created a situation in which probation officers appear to be uncertain as to the direction of travel of the new services which have emerged, maintaining that the restructuring of the probation service has led to a noticeable paradigm shift underpinning the ethos of supervision from one focused on facilitating rehabilitation to one focused on avoiding re-offending. This suggests the need for evidence to explore the impact of the restructuring of the probation service on the wellbeing of offenders and probation managers as well.

7.6.3 Trust issues

The narratives of the silent voices indicate that although participants did not complain about the supervision received, they felt that total disclosure to a probation officer even around issues concerning health could unwittingly land the offender in trouble with the law. This was corroborated in the collective dialogue and suggests the need for a health service which is nurse led as opposed to one in which probation officers are equipped with the skills to deliver any proposed intervention. Furthermore, this issue of trust also underpins the need for a nurse led service to be modelled on the data protection protocols which mirror those of primary care.

7.6.4 Cost of primary care services

The silent dialogue indicated that accessing dentists and opticians in the community as a non-paying patient is extremely hard for offenders as the providers of these services appear to prefer paying patients to NHS patients. Most offenders do not have the means to pay for these services on release or the agency to advocate on behalf of themselves with a medical practitioner. This reinforces the need for a nurse led service which would signpost offenders to services and advocate on their behalf in circumstances where they encounter discriminatory practices.

7.6.5 Disparity in post release health services

While there is some provision for addressing the mental health and substance misuse needs of offenders on release as a unique group, it was uncovered that services to address their physical health needs as a group in need of tailored support is non-existent. The assumption is that offenders on release will access services for their physical health needs through the channels open to other members of society. Although this disparity is in part due to the fact that there is very little evidence to suggest the implication of poor physical health on re-offending, this state of affairs suggests the need for research aimed at exploring the adverse physical health needs of offenders and clearly conveying the relationship between these health needs and the released offenders risk of reoffending.

7.6.6 Offender families

Although the silence dialogue did not indicate this, it was uncovered in the collective dialogue that there is a need for the family members of offenders to also be provided

with support in enabling them to cope with the released offender on release from prison. In the context of the present economic climate, it is safe to posit that the appetite for the provision of such an intervention by the criminal justice system is constrained. However, it is advised that support services which already exist in the community be tapped into with the family members of offenders referred into these services.

7.6.7 GP surgeries declining to register offenders

It was uncovered that some GP surgeries were refusing to register offenders for reasons such as the lack of a fixed abode or not having an appropriate means of identification. In addition, probation officers are unable to advocate for ex-offenders who get refused registration due to their lack of information on the stipulated national guidelines in England and Wales governing GP patient registrations. This reinforces the need for a nurse led service in which offenders who get refused registration could be advocated for. Similarly, this also speaks of the need for probation officers to be provided with the requisite information governing registration with GP surgeries within their local areas.

7.6.8 Literacy assumption

The practices of probation officers presuppose that all offenders can read. This is evidenced in their practice of introducing themselves to offenders via the means of a letter. This assumption is flawed as there is evidence to suggest that most offenders have below average literacy skill and have trouble asking for help (Social Exclusion Unit, 2002). The Social Exclusion Unit (2002) reports that 80% of prisoners have

writing skills at or below the level expected of an 11-year-old child, the equivalent figure for reading is 50%. Consequently, the practice of writing letters without thought to whether or not the offender can read unwittingly excludes those offenders who cannot read and supports the need for alternate forms of establishing contact with offenders. Towards achieving this, it is advised that probation officers meet their licensees in person prior to release. However where this is not possible and contact is made in writing, it is important that probation officers conduct prior checks aimed at uncovering if indeed the offender has the literacy skill to understand what has been written.

8.0. CHAPTER EIGHT – PLANING FOR SILENCES – Research recommendations (Silences-Stage 5)

This stage addresses the Silences uncovered in all stages of this study and sets out options for addressing them. The stage will set out recommendations for facilitating the continuity in access to healthcare for offenders on release in the community by making recommendations which encompass the pre-release, on release and post release phase of their journey through the criminal justice system. Recommendations will also be made towards the provision of a nurse led service and in addressing the Silences which were uncovered from the narratives of the research participants. Towards ensuring that this study did not further silence the voices of the silent voices, the recommendations made herein have been contextualised to the suggestions of these voices.

8.1 Pre-release

- It is important that prisons endeavour to prepare offenders irrespective of their health status pre-release for accessing healthcare in the community. In line with the ethos of re-integration, this preparation should ensure that on release, offenders possess the agency to truly navigate and access primary health services. This pre-release process should enquire on whether an offender has a GP in the community. Where individuals disclose that they do not have a GP, advice should be given on the access points to primary care in the community to which they will be released.

- Prison offender supervisors should adopt a proactive role in enquiring and discussing the health needs of the offenders they manage irrespective of the perceived non-causal relationship of such a need on re-offending. Doing this could potentially ensure that prior to release, offenders give thought to how they will be addressing their health needs on release in the community.
- Probation officers should endeavour to meet their licencees in prison prior to release in order to ensure that these individuals understand that their role is not one which is oriented towards punishment but one which is focused on support aimed at enabling them avoid circumstances which may lead to re-offending. This will ensure that a relationship is built prior to getting released and the apprehension which governs the first encounter with the probation officer on release is addressed. Where probation officers are unable to meet their licencees in person, the use of a video link is recommended. Where this facility does not exist, it is advised that contact be made by means of a phone call or in writing. However where contact is made in writing, it is important that probation officers conduct prior checks aimed at uncovering if indeed the offender has the literacy skill to understand what has been written.
- Where offenders have been visited by their probation officers in prison, it is recommended that the officer enquires on whether the individual has any physical health issue. It is acknowledged that there would most likely be a discussion around mental health and substance misuse due to the high correlation of these on reoffending. However, it is advised that the physical health needs of these individuals be discussed as individuals with a mental

health or substance use health problem are most likely to be in poor physical health.

- It is important that every contact with a health practitioner in prison be supported with information which could enable the offender to continue to access healthcare on release from prison. This will be particularly useful for revolving door offenders who indicate that while they find the experience of imprisonment unpleasant, they recognise and use imprisonment as a period for the uptake of health interventions as opposed to seeking out these interventions in the community on release.

8.2 On release

- Collaboration is needed between the probation service and NHS England towards developing a pathway to facilitate registration with primary care services (GP and Dental Surgeries) for licencees. Such a pathway could end in the provision of temporal registration for individuals on release with a specific surgery in the area. This would work on the basis of commissioners establishing a service agreement with the surgery/s to provide temporal registration.
- There are no clear pathways for the transfer of patient clinical records between prison and primary care. This speaks for the need of commissioners of both prison and primary healthcare to collaborate in creating an IT system which seamlessly interphases between both settings. Such a system should ideally contain information about offenders' physical and mental health, as

well as a history of service contact. However, it is acknowledged that the commissioning of primary care by individual clinical commissioning groups maybe an issue mitigating against this as individual clinical commission groups will have varying priorities. Consequently, it is suggested that the National Health Service Commissioning Board or NHS England be responsible as the oversight body in charge of bringing such a system into practice.

8.3 Post release

- There is a need for probation providers to explore the provision of mentoring schemes to provide support for individuals in the immediate weeks following the end of supervision. This will ensure that at the end of supervision, support is received from individuals who are not likely to entice the newly released offender into reoffending. However, in the provision of such a scheme, careful thought must be given to the financial, legal and human cost which will be incurred in the provision of such a scheme. Such a scheme could be modelled on the peer led support provided by St Giles Trust.
- It is important that any proposed mentoring program use as mentors individuals with a prior experience of the criminal justice system. This will ensure that mentoring is provided by individuals with first-hand knowledge of the experience of imprisonment and the challenges of reintegrating into society on release from prison.

- Consideration should be given to the provision of an open evening where issues revolving around health such as access to primary care could be explored on a monthly or fortnightly basis as appropriate. Community practitioners such as dentists and GP's could be invited to come in to discuss accessing services and the rights of offenders in accessing primary health services locally. This could potentially educate offenders on the appropriate routes to accessing these services in the community. However, in the provision of such an evening, thought must be given to the timing of such an event so as not to unwittingly exclude certain category of offenders such as those in employment or education. Perhaps alternating the timing of the events may be a more inclusive approach overall.
- Probation officers should be advised on the rights of licencees in accessing primary care. This will ensure that where licencees are denied primary care services for reasons which contravene the principles governing the provision of primary care in England and Wales, probation officers are equipped with the information to enable them to advocate on behalf of these individuals and if necessary, report providers in breach to the local clinical commissioning group.
- Where a probation officer sign posts an individual for registration with a primary care service, it is recommended that the officer follows this up by enquiring during supervision whether registration was accomplished.

- It was uncovered that offenders were not aware of the range of services available to them during supervision. This speaks for the need to disseminate the services available at the probation trust widely. Accordingly, it is advised that probation officers explain the range of services accessible to the offender on first contact in the community on release from prison. Furthermore, it is advised that leaflets promoting the range of services available at the trust be left at the reception waiting area.

8.4 Nurse led service

- This study indicates that a nurse led service can facilitate continuity in access to healthcare on release from prison for offenders while concurrently addressing their presenting health needs in the community. However, it is important that any provided service be easily accessible with due consideration given to the accessibility of the location in which the service is to be sited and the timing of such a service.
- With regards to an appropriate location for the siting of a nurse led service, it is advised that the service be located within the premises of the probation trust. This is because it is unlikely that individuals undergoing supervision in the community will be unable to locate and access the premises in which they are being supervised. However, in doing this, it must be ensured that the provided service crosses the span of both high and low risk offenders.
- It is important that the remit of the nurses and their role within the service be clearly defined and conveyed to all parties concerned. This will ensure that

probation officers and service users are clear about the degree to which the nurses employed in this role would be of help.

- It is important that any provided nurse-led service be structured as an advisory and not a treatment service. This will guard against the danger of compromising the resilience which the supervisory process is designed to instil as service users will be required to engage with the services they have been referred to in person. Moreover, this will ensure that no harm is unwittingly done through the provision of the service as on termination of their supervision, custodial based offenders will have developed the agency to access primary care community based services themselves.
- Although it is advised that the provided service be structured on an advisory basis, in the consideration for the addition of a treatment component, careful thought must be given to addressing issues associated with the provision of healthcare in a non-healthcare environment such as infection control.
- This study uncovered that it is important for the nurses employed in the role to be conversant with the primary care services which exist in the community. This speaks for the need of the nurses employed in this role to develop links in the community and be proactive in understanding the referral pathways accompanying the health services which exist within the service area.
- Although it is acknowledged that a nurse with an urgent care background may be conversant with caring for offenders, it is recommended that this should

not constitute a requirement for recruitment into the role. Whilst, this may be desirable, it is advised that knowledge of the services which exist in the community and the referral pathways into these services be prioritised as more important in the recruitment of a nurse into the role.

- It is crucial for the nurse employed in this role to establish direct links with all the local prisons in the area. This is cost-effective to physically commuting into prisons and could potentially facilitate the transfer of patient clinical information between prison and primary care by ensuring that where nurses fax request for notes from prisons, it will be acted upon quickly and seen as a priority.
- Any provided service should build on the established principles of data protection which govern the confidential relationship between clinician and patients in the UK. However, in situations where the health circumstance of the patient could potentially constitute a risk to the patient or public, then it is important that this be disclosed to the probation officer.
- A joint written agreement between the health provider and the probation trust must be adopted to inform and guide the information sharing procedure of the service. Importantly, it is recommended that all service users be made aware of this information sharing policy on their first contact with the service.
- It is advised that any provided service operate as an appointment and drop in service. Having the service run on both formats will ensure that the service is

constructively aligned to the lived realities of the chaotic nature of offenders' lives on release from prison.

- The nurses employed to the role must endeavour to collate the outcomes of provided interventions whether it is advice or referral. This will evidence the effectiveness of the service and the outcomes of provided interventions.
- Probation officers should be provided with information on the remit and potential benefits of any provided service whether it is a nurse led advisory service or an open evening. This will ensure that probation officers have the appropriate information to relay and refer the service to their cases which in-turn could positively impact on the uptake of the service.
- In ensuring that any provided service is taken up appropriately, it is advised that probation officers refer individuals to the service during supervision and enquire subsequently from them if they attended. However, in doing this, probation officers must convey to supervisees that engagement with the service is voluntary and has no consequence on their licence condition.
- Presently and politically, the financial climate in England and Wales is so austere at the moment that only high volume, highly efficient, cost effective services are being considered to be commissioned. Therefore, it is crucial that an economic case be made in advising commissioners on the need for a nurse led service. This case should evidence the poor health status of offenders on release from prison and build on the potential cost savings to be

had as a consequence of the appropriate use of primary care services by custodial community based offenders. In addition, it is advised that such a case must evidence both the need for such a service and the demand for it by offenders.

8.5 Uncovered silences

- In the provision of a nurse led service, an economic case must be made to justify the role to be performed by the nurse. This should build on the knowledge base and expertise which nurses already possess as a consequence of their training and practice which guarantees that they do not need to be trained for the role. However an alternative to employing a nurse in the role could be having the intervention commissioned or co-commissioned by the NHS and using one of their already trained members of staff to carry out the role as part of their wider role within the NHS. However, the danger of employing a non-clinician to the role is that doing this could potentially expose the service to a situation in which clinicians in both the community and prisons may not want to engage or discuss the clinical needs of service users with such an individual, citing clinical incompetence as an excuse in justification.
- All offenders as part of their pre-release preparation should receive advice on accessing primary care on release in the community. Such advice could be delivered by a member of the prison healthcare team and should concurrently address commonly encountered health challenges such as registering with primary care providers. Doing this could empower the offender with the agency to access primary care appropriately on release in the community.

Moreover, this could lead to cost savings as potentially, this could lead to a reduction in the crisis use of emergency medical services by offenders in the long-run.

- Making registration with a GP, a license requirement on release should be explored. Legally, this could be done by establishing that the MOJ owes a duty of care to offenders. Accordingly, it could be argued that registration with a GP on release is aligned with this ethos. Doing this could potentially reduce ex-offenders crisis use of services on the one hand, and on the other hand could lead to potential cost savings as a consequence of a reduction in the crisis use of medical services.
- In the provision of a mentoring service, it is advised that probation trusts at a local level liaise and work in partnership with organisations in the community towards getting involved in their various mentoring schemes. This will ensure that services which are already available at a local level are tapped into, thus, ensuring cost savings which otherwise will be incurred if such a service was to be provided by the probation service. This could also work on the basis of collating the services which presently exist locally and at the end of license, referring individuals on to these services.
- Due to the work pressures presently being encountered by probation officers, the temptation does exist for contact with the nurse led service to be used as a means of supervision. This is counterintuitive to the principles of a therapeutic relationship. Accordingly, it is important that any provided service

guards against this and that service users are appropriately advised that engagement with the service is strictly of their own volition and has no implication on their license condition.

- Members of the CJS should endeavour to adopt a proactive approach in enquiring on the health of offenders. In doing this, they should adopt the ethos of making every contact count as this could potentially improve the health outcomes of offenders and consequently lead to desistance from crime.
- Due to the restructuring of the probation service, it is important that the commissioners of any proposed service establish clear lines for accessing the service which do not unwittingly exclude any category of offenders. For example high risk (NPS managed) at the expense of low risk (CRC managed).
- It is crucial that measures be put in place to monitor, facilitate and ensure that contact does indeed occur between offender managers in the community and offender supervisors in prison with regards to the exchange of information on the 'about to be released offender'. This will forewarn offender managers on the services which may be needed by an offender on release and could potentially facilitate the supervision on release which is person centred.
- There is a need for the family members of offenders to also be provided with support in enabling them cope with the released offender on release from prison. In the context of the present economic climate, it is safe to posit that

the appetite for the provision of such an intervention by the criminal justice system is constrained. However, it is advised that support services which already exist in the community be tapped into with the family members of offenders needing help referred into these services.

- In addressing the preparedness and safety concerns of nurses for this role, it is advised that safe guards through training and skill acquisition be put in place to assure the safety of the individual recruited to the role.
- It was uncovered that the help received by an offender in prison is not clearly conveyed to the offender manager and primary health provider in the community. This clearly indicates that there is a lack of joined up working between the health department in prison and probation and primary health providers in the community. Accordingly, this speaks of the need for establishing clear and regular communication pathways between these bodies.
- Although guidance has been produced on the application of the data protection act in relation to the use and disclosure of health data, such guidance appear not to have filtered down to frontline staff as can be deduced from the findings of this study. This speaks for the need of training to be delivered to members of the CJS bordering on the data protection act and health disclosure. This also underlies the need for interagency collaboration and timely information sharing between the criminal justice system and the National Health Service.

9.0 CONCLUSION

This final chapter of this study highlights the extent to which the study findings can be generalised to a wider population and identifies some of the possible 'risks' that could arise from acting on the findings. Reflections on the theoretical contributions of underpinning this study with the Silences Framework and the possible impact of the findings on the current context of offender health are also presented. Finally, this study concludes with a reflexive account of the lessons learnt by the researcher as a consequence of engaging in this piece of work.

9.1 Study limitation

As a case study, it is acknowledged that this study cannot be generalised to all offenders as the sample size, gender and age distribution did not mirror the wider offender population in England and Wales. However, it is important to note that overarching generalisations is not the intent of case studies (Yin, 2009) and was correspondingly not the intent of this study. Furthermore, the silence dialogue only involved custodial based offenders on licences and it is not known whether being imprisoned at the time of interview will present a different perspective to the narrative of these voices. This suggests the need for a large scale study which is representative of the entire offending population and which seeks the views of offenders in prison alongside those on custodial based community licenses on the provision of a nurse led service in the community. Accordingly, it is posited that the 'probable risk' that could arise out of adopting the findings of this study is that it may not be generalizable to the entire offender population. However, it should be noted that this risk was mitigated against as a result of seeking the views of individuals in the professional networks of offenders whose professional roles impact on the lived

realities of offenders' lives. Moreover, the limitation associated with the study generalizability was further mitigated against by the general applicability of the study as a consequence of the set of methodological instruments which were used and the rigour with which these were applied and in how this study was planned, piloted, and implemented.

A major strength of the qualitative approach is the depth to which explorations are conducted and descriptions are written, usually resulting in sufficient details for the reader to grasp the idiosyncracies of the situation (Myers, 2000). In this context, it is important to consider the aim of a study when evaluating its quality. Problems related to sampling and generalizations may have little relevance to the goals of the study and the reality of the situation as a small sample size may be more useful in examining a situation in-depth from various perspectives, whereas a large sample would be inconsequential (Yin, 1994). The overarching aim of this study was to identify touch points in the community where a nurse led intervention could be provided to offenders in the community. Whilst it is acknowledged that following up a larger population of offenders would have provided more weight to the outcomes of this study, it is nonetheless posited that following up the eight cases who engaged in the study in-depth over the course of six months enabled the researcher to explore from various perspectives their construction of a nurse led service and touch points in the community were they felt they would like such an intervention to be provided. With a large sample size, this would have otherwise been impossible to achieve due to the constraints of time and resource.

It is important to also note that a probable risk that could arise as a consequence of acting on the findings of this study is that probation officers may unwittingly use a

nurse led service as a means of supervision. This should be guarded against as it is disingenuous and counterproductive to a therapeutic relationship to underpin health with the loss of liberty. Furthermore, as part of their roles, probation officers are expected to advice and signpost offenders on health matters irrespective of whether the presenting health issue has an impact on re-offending. However, the danger does exist for probation officers to see the provision of a nurse led service as a substitute for this role and may unwittingly lead to a situation in which the first response of a probation officer with regards to the health need of a case will be to refer into the service. This should be guarded against with probation officers ensuring that they use every contact with an offender as an opportunity to pass across a health message and only refer into the service in instances where they feel they are not ideally positioned to meet the health need of the client.

9.2 Reflection: The Silences Framework theoretical contribution to study

The underpinning of this study using The Silences Framework situated the study within a theoretical framework which is ideally suited for investigating the healthcare needs of a marginalised population and consequently facilitating the exploration of an under researched area. This enabled this study to gain theoretically by situating power with offenders and thus enabling their Silences to be heard, explored and brought to light. Doing this addressed the consistent uni-dimensional presentation of evidence revolving around the health of custodial based offenders in which evidence is conveyed through the lens of professionals. The use of this framework further facilitated the active recognition of the marginalised context in which the perspectives of offenders are located by positioning the study within philosophical approaches which recognise that all aspects of life are influenced by a range of

factors which include human beliefs, social change and politics. This therefore encouraged the exploration of a nurse led intervention for custodial based offenders within the theoretical and political context of offender health in the UK.

Although the use of this framework was aimed at uncovering the Silences of offenders situated in the context of the provision of a nurse led intervention, this framework also enabled the researcher to locate self within the study. This was pragmatically useful as this ensured that the trustworthiness of the study could be assessed in light of the Silences which emerged rather than in spite them. In addition, the use of The Silences Framework further facilitated the exposure of the real world in which this research took place. This enabled the contextualisation of the realities on ground and what was not evident or reported utilising the evidence and information sources easily accessed in the current public domain. In essence, the use of this framework enabled the researcher to clearly address for the reader the key question 'why research this study at this particular time?' based on exposure of 'what we don't know'.

Furthermore, the user friendliness of this framework and the linearity and logical nature in which the stages of the framework built upon self was a pragmatic gain which was achieved as a consequence of using this framework to underpin the study. This simplified the conduct of the study as at every stage, the researcher was clear on the outcomes to be had as a consequence of engaging in the present stage and conscious of how the present stage was going to fit into the next stage. In other words, using this framework was similar to building a pyramid in which the building plan had been provided and the researcher could see at every stage how each level was crucial for the development of the next.

Moreover, the non-prescriptive nature of The Silences Framework on the choice of methods for a research study was a pragmatic gain which was achieved as a consequence of the use of this framework. This ensured that the research methods which were employed were informed by the study research design alongside considerations for achieving the study aim and objectives. Another pragmatic gain which was achieved as a consequence of the use of this framework was that it facilitated the provision of plans to address the Silences uncovered. This was significant as it enabled custodial based offenders to not only voice their Silences, but importantly, also suggest how they would like these Silences to be addressed in a manner and way in which they felt, would not be stigmatising and would be agreeable to them in the context of their lived realities.

In accepting that 'Silences' exist as an inherent part of all societies, The Silences Framework also acknowledges that on completion of a research study, some 'Silences' are changed, exposed and even newly created. The use of this framework enabled this study acknowledge the potential and probable risks that could arise from acting on this research in view of the findings which were generated. The pragmatic gain to be had as a consequence of doing this was that this revealed the limitations of this study. This serves as a cautionary note for any follow-on study on the potential dangers which must be guarded against, and concurrently, as a foundation from which to build upon.

9.3 Reflection: impact of finding on current context of offender health

The health needs of released offenders are significantly greater than those of the general population with a lack of equity existing between need and supply. The

current context of offender health indicates that offenders re-enter their communities with limited pre-release preparation for the continuity in access to healthcare once outside prison. This context indicates that offenders are at an increased risk of release into the community with a health condition and very little support to cope in the community on release (WHO 2007, van den Bergh *et al.* 2011). Once released, offenders become hard to reach, do not consider health a priority and use services to address their health and social care needs in a crisis led way. This is further exacerbated by the fact that most released offenders are not registered with a general practitioner which mitigates against the ethos of continuity of care on release (Norman and Parrish 2002, Marlow 2008, Rennie, Senior and Shaw, 2009, Norman, 2010). These individuals are not a new group in need of support, on the contrary, they are a group which is visible in practice but lack recognition in policy (Pager 2006, Brooker *et al.* 2008). Accordingly, the current context of offender health evidences the fact that offenders re-enter their community with significant health problems and a limited understanding of how they can access health and social care services.

Whilst this study uncovered on the one hand that nurses are uniquely positioned to initiate and sustain contact with offenders by intervening at points of greatest need in the community to address the socially significant health and social care issues which plague them, on the other hand, the current context of offender health concurrently corroborated by this study indicates that current dominant discourses around equity of care are contradicted in the provision of health and social care services to offenders on release from prison as a marginalised group in need of tailored support. Accordingly, this study uncovered the consistent lack of pre-release support aimed at ensuring that offenders continued to access healthcare on release from prison in the

community. In addition, a lack of recognition of offenders as a suspect class in need of tailored health interventions on release from prison was also uncovered. Worryingly, it was also uncovered that attempts to improve offender health both in and out of prison is focused on offender mental health, which reflects priorities in terms of the size of the prison population with mental health problems, links with reoffending and protecting the public. Ominously, this has meant that the development of physical health pathways, chronic or acute, and often co-morbid with mental health issues, has been neglected and is evidenced in the disparity between services which address the physical health needs of offenders and those which address their mental and substance misuse health needs on release.

The impact of the aforementioned findings on the current context of offender health is that firstly, the use of nurses in the provision of health and social care interventions to offenders on release in the community is a strategy which could increase equity in access to healthcare, reduce reoffending and improve both the health and life chances of these individuals. Secondly, while there is a profound understanding of the scale of the health issues plaguing offenders, there is less understanding on the part of research and policy on how to connect these individuals to needed services in the community. Indeed, much of the research on the health and social care needs of released offenders is descriptive in nature and not evaluative of currently available programs. Moreover, these studies have historically not been experimental in exploring what programs and interventions may be the most effective for getting offenders to access services in the community. Therefore, it is important that research begins to focus further on exploring and understanding what works with regards to linking newly released offenders to health and social care services delivered in the community and whether such care could play a role in increasing

released offenders opportunities for successful reintegration. Thirdly, it is obvious that the importance of working with offenders prior to release and on-release cannot be overemphasised as this has the potential to enable the offender to prepare and plan for their continuity in access to health services in the community. However, it is clear that in practice this does not happen, and underpinned by the findings of this study, it is safe to posit that offenders do not feel that they get enough support to plan for what will happen after they are released with regards to their health. This must be addressed. Finally, whilst it is acknowledged that the mental wellbeing of offenders is of importance, it is posited herein that addressing these needs should be done in a manner and way which concurrently recognises and addresses the physical health needs of offenders as well.

9.4 Future work

As a consequence of the above reflection on the possible impact of the findings on the current context of offender health and the Silences which were uncovered in this study, it is important for this study to propose areas of future work. This is done in order to ensure that the evidence generated by this study while addressing some existing gaps, concurrently informs the context in which further research in this area will occur by sitting as part of Stage 1 of subsequent similar studies using this framework. In line with this ethos, the following are areas in which future work is proposed:

- Research is needed to evidence the extent to which ex-offenders use medical services in a crisis led way and the reasons behind their use. This could

potentially provide the evidence to inform making registration with a GP surgery a license requirement on release.

- Research is needed which clearly conveys the link between physical health and re-offending. While there is an abundance of research illustrating the link between mental health and substance misuse on offending, this does not translate to physical health and consequently affects the political construction of offender health with regards to areas of need post release. This study indicates that this has consequently affected practice in that there are no services dedicated to addressing the physical health needs of ex-offenders as a unique group in need of tailored support.

- Evidence the prevalence of poor physical health in custodial based offenders using the number of missed appointments as an indicative tool:

It was uncovered although anecdotally over the course of this study that a significant amount of custodial based offenders were missing their supervisory appointments through ill physical health. Towards exploring the relationship between physical health and reoffending, research could explore the amount of appointments missed by supervisees due to ill health and correlate these to non-engagement with the probation service. These non-engagements are directly proportional to the missing out on interventions aimed at ensuring that custodial based offenders do not reoffend. These non-engagements can then be correlated to whether or not they reoffend, thus, contributing to the evidence base for the relationship between poor physical health, re-offending

and the cost consequences of missing out on supervisory interventions through poor physical health.

- This study indicates that the transfer of patient clinical records between the providers of prison healthcare and primary care in the community is not fit for purpose. Accordingly, research is needed to evidence the need for an IT health system which seamlessly connects both healthcare systems.
- This study uncovered that the restructuring of the probation service has had an effect on the quality of supervision provided to offenders. This suggests the need for work exploring the impact the restructuring of the probation service has had on the wellbeing of offenders and probation managers.
- The criminal justice system in England and Wales has various categories of prisons that range from closed to open with prisoners often moving through the establishment as part of their preparation for release. The extent to which this transition through the establishment affects the uptake of healthcare on release remains largely under researched and is an issue in need of exploration. Such exploration could inform practice on the appropriate stage to begin to empower prisoners with the needed skills necessary for accessing healthcare post release in the community.

9.5 Reflection on the learning experience

In conducting this study, I endeavoured to locate my contribution to constructs and meanings throughout the research process and acknowledged the impossibility of

remaining 'outside of' the subject matter whilst conducting this research. In exploring personal reflexivity, I considered my role as the knowledge constructing agent and recognized the ways in which my values, experiences, interests, beliefs, political commitments, wider aims in life and social identity have shaped this research. Consequently, my belief in the principle of equivalence with regards to access to healthcare for offenders influenced the manner in which this study was conducted. Whilst I endeavoured through my use of The Silences Framework to be aware of my beliefs, value and assumptions in order to ensure that I convey as accurately as possible the research process, my engagement in this study enabled me to understand that I cannot view any part of the world without affecting it as an individual. This idea is central to this work and is a fact I hope to always recognise and acknowledge for the rest of my research career and as a practitioner of public health.

As an early career researcher and subjective-interpretive being, I encountered certain challenges with using The Silences Framework to underpin this study. The Silences Framework allowed for a great deal of flexibility due to its non-prescriptive nature which was quite daunting for me as a new researcher. Although, I acknowledge that this has its own merits, the flexibility of this framework meant that I consistently had to be reflexive at every stage with regards to given thought to the rationale behind every activity employed in the study. The problem herein was that I found it easy to be objective in my choice of research instruments but found it difficult to reconcile my subjective preference for these instruments.

Furthermore, the fact that the framework advocates for an iterative process which involves continuing the analysis phase until saturation is reached was an issue which I initially found hard to reconcile. It is a fact that as individuals, our realities and lived

spaces alter with time, with our ideas and lived experiences continually shifting depending on our present circumstances at every point in time. Accordingly, I wondered initially when I set off to use this framework if saturation would ever be reached and how I would recognise this when it was achieved. However, as I began to carry out this piece of work in line with the stages recommended by The Silences Framework, I discovered that the stages addressed this issue as the framework is designed to continually check and recheck uncovered findings with the individuals researched. This also addressed the problem of double hermeneutic which I encountered as a consequence of reality being interpreted by offenders and their construction explained by me. Whilst it is acknowledged that this double interpretation could potentially affect the trustworthiness of a study, this study mitigated against this through the adoption of an iterative process aimed at corroborating researcher interpretation.

Additionally, I have reflected upon how this research may have affected and possibly changed me, as an individual and as a researcher. My interpretation of offender health in England and Wales is that it is an issue which is easy to connect with emotionally without necessarily knowing what the political context is. As an individual, this research has very much aligned me with the sociological rationale for offending and crime. I have come to see first-hand how sociological factors such as deprivation and unemployment lead individuals to offending. Over the course of this study, I found myself thinking that my participants and I may not be all that different. Perhaps, I may have turned to crime if I was abused as a child, came from a home in which my parents and siblings were abusing and dealing drugs, dropped out of school because it was expected that I would, and found it difficult to keep a job because I never developed the skills congruent with being employed. Whilst it is

possible for individuals to emerge from such circumstances without turning to a life of crime, it is my position as a consequence of engaging in this study and interacting with offenders that the inaction of the state to an extent unwittingly predisposes individuals to offending and offending behaviour. Whilst I think this is wrong, I don't think it is terribly surprising. Consequently, I believe that it is disingenuous to suggest that the experience of offenders will be the same as other members of society as all groups are conditioned by their specific histories (Spirkin, 1983). This to my mind suggests the need for a look at offenders as a unique group in need of tailored support.

As a researcher, I have now come to realise that the context in which a narrative is given is crucial to understanding the meanings the narrative is meant to convey. Prior to conducting this study, I felt that the analysis of the narratives of my research participants was going to provide a 'fool-proof' answer to my research question, as long as these narratives were properly analysed. However, I have come to learn that whilst narratives provide a window into reality, discovered reality arises from an interactive process with the context of the narrative and an in-depth understanding of the factors which necessitated the need for the narrative in the first place. This has greatly informed my understanding of the process of knowledge creation and the importance of understanding the context in which a research is situated. I have also learnt that describing lived experiences is complex and difficult; but language, speech and systems of discourse mediate and define the experiences we attempt to describe. Thus to understand these, the representations of experience, and not experience itself are studied. Finally, this research has increased my knowledge and

awareness of offender health and has afforded me the opportunity to understand that the process of conducting a research is as important as the end result produced.

9.6 Contribution to knowledge

This study contributes to knowledge by making original contributions to the wider context of offender health, identifying opportunities for nurse led interventions in offender health and in the use of the study methodology itself.

9.6.1 Wider context of offender health

This study uncovered the lack of a holistic approach in the provision of health interventions targeted at ex-offenders post release as a unique group in need of support. While there is some provision for addressing the mental health and substance misuse needs of offenders on release as a unique group, services to address their physical health needs as a group in need of tailored support is non-existent. Whilst it has been previously evidenced that this disparity is in part due to the fact that there is very little evidence to suggest the implication of poor physical health on re-offending, this state of affairs suggest the need for research aimed at evidencing the adverse physical health needs of offenders and clearly conveying the relationship between these and the released offender risk of reoffending.

However, the original contribution arising out of the aforementioned context is the identification of the unwitting construction of the health of offenders in literature, policy and practice exclusively through the lens of mental health and substance misuse at the expense of physical health.

9.6.2 Opportunities for Nurse led interventions for offender health

The overarching aim of this study was to identify 'touch points' in the community where nurse led interventions could be delivered to ex-offenders. The study key question was: 'Where and how can health interventions be provided by nurses to released offenders now living in the community?'

The study's original contribution with regards to this research question is the identification of this touch point in a manner and way which was ethical and informed by ex-offenders themselves. The study identified the site of post-release supervision as the touch point where a nurse led intervention could be delivered. With regards to the delivery of the health intervention, this study indicated that the nurse led intervention be provided as an advisory and signposting service and be structured on a drop-in and appointment basis.

9.6.3 Study methodology

This study adopted the use of the Silences Framework as a theoretical base. The concept of 'Screaming Silences' emerged from a doctoral study which was designed to explore the experiences of black Caribbean men, their sexual decision making and risk taking (Serrant-Green, 2004). The Silences Framework emerged from this concept and was originally presented for use to be tested in research and practice settings (Serrant-Green, 2011). The key issue in relation to an original contribution is that, this framework has never been used to underpin Doctoral research prior to this study.

In this aspect, this study makes two methodological original contributions to knowledge. Firstly, this study is the first of its kind at a doctoral level to adopt the use

of the Silences Framework to underpin research, thus using theory in testing out a framework which has not been used previously. Secondly, this study uses the framework in a completely different context from the context of the original research through which it was designed. To reiterate, the original context of use was to explore black Caribbean men's sexual health behaviour and risk. After use in this context, researchers were invited to use and test the framework in different other contexts (Serrant-Green, 2011). Accordingly, this study at an original level, generally adopts the use of the framework for the first time to inform offender health on the one hand, and specifically on the other hand, to inform the provision of a nurse led intervention for ex-offenders in the community.

Furthermore, another original contribution in the context of methodology is the adaptation of The Silences Framework to align with how the findings of this study were presented. On the one hand, in adopting an anti-essentialist perspective, the voicing silence stage conveyed the reality of participants and presented facts from their perspectives as a consequence of their position in the social world. Yet, on the other hand and in adopting a criticalist approach, the working with silences stage contextualised the findings generated from both the silence and collective dialogue to the realities on the ground. The Silences Framework in its original context is underpinned by both anti-essentialist and criticalist concepts and advocates that all its stages be underpinned by both concepts. However, the modification made herein was ideally suited to offender health research as the voices of offenders in offender health discourse are silenced and marginalised from policy and practice. Consequently, this modification enabled the voices of offenders to be heard without interference from the situated context of offender health from the perspective of the researcher, policy or even practice.

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Appendices

Appendix I: Ethics application

Chief Investigator (Name): Cyril Eshareturi

Title of the Research: Process Mapping the Released Offender Health Pathway

Category: B (requires approval from other ethics committee)

Key Words: Ex-offenders, Nursing, Community, Health and Wellbeing, Social Care, Reoffending, Re-entry, Criminal Justice System

Chief Investigator's Details (Must be completed)

Title: Mr

Forename: Cyril

Surname: Eshareturi

Position: Doctoral Student

Qualifications and Professional background: BSc, MPH

Email address: Cyril.Eshareturi@wlv.ac.uk

Address: University of Wolverhampton

Centre for Health and Social Care Improvement

ML117

Deanery Row, Off Molineux Street,

Wolverhampton.

Postcode: WV1 1DT

Telephone number: 01902 518644

Alternative contact number: 07759303286

Supervisor's Name and contact number: Prof Laura Serrant-Green. 01902518627

How many words is your proposal? 1427

Please LIST the major ethical issues you have discussed in the attached research proposal.

- Data protection
- Confidentiality
- Ethical approval from other committees
- Disclosure of potentially dangerous information
- Coercion and consent
- Handling of potentially distressing situations to participants
- Handling of potentially aggressive situations by researcher
- Data storage time

Declaration

Chief Investigator Signature Cyril Eshareturi

Supervisor Signature Laura Serrant-Green

Title of proposed research

Process Mapping the Released Offender Health Pathway

Background / justification for conducting the study

The National Health Service Commissioning Board is responsible for the healthcare of imprisoned individuals; and for individuals who are not but still in contact with the criminal justice system, individual clinical commissioning groups are responsible for their health and social care needs (Department of Health, 2011). The question herein is: what happens to offenders released into the community not in contact with the criminal justice system? Available evidence simply does not know. Anecdotally, it is assumed that these individuals leave prison to reintegrate back into society and consequently access health and social care services through normal channels. On the contrary, available evidence indicates that these individuals are hard to reach; use health services in a crisis led way and are socially excluded (Williamson, 2006; Marlow, 2008; Sainsbury Centre, 2008; Rennie, Senior and Shaw, 2009; Norman, 2010; Byng *et al.*, 2012). Moreover, available evidence indicates that offenders released on licence also have considerable health needs and suffer from the absence of health and social care interventions oriented towards addressing their needs as a health excluded group (Brooker *et al.*, 2008). Consequently, this suggests that there is a need to build the evidence base around community based management of released offenders by providing an overview of their health needs from their own perspectives, exploring current level of support aimed at improving these needs and concurrently positing how identified health needs could be addressed in the community.

Purpose of the research

The purpose of this study is to map the released offender health pathway in order to identify 'touch points' in the community where nurse led interventions can be delivered.

Potential Benefits arising from the Study

This research will be of benefit to the released offender population as its overarching aim is to uncover what their health needs are from their own perspective and concurrently identify ways of meeting these needs which are agreeable to them in the community. In addition, this study will also benefit commissioners and providers of health and social care services as the study will generate evidence to guide and inform service provision for released offenders in the community.

Research Design

This study will employ a mixed method approach using both qualitative and quantitative methods in collecting data. The research will adopt the use of a questionnaire as a source of baseline data in providing the general health profile of 50 research participants. This will then be ranked on the basis of poor health with the 5 top ranking individuals of either gender (5 male and 5 female) selected as cases to be followed up prospectively for six months. The use of the case study approach is adopted because it builds on actual practices and experiences which could be linked to an action (Blaikei, 2009). Available evidence on offender research indicates that the use of this approach permits in-depth analyses of a small sample size (Millward and Senker, 2012). Indeed, this approach has been used in evaluating a reintegration service for long-term dangerous offenders on release (Day *et al.* 2011) and in examining community re-entry experiences of individuals with intellectual disability leaving prisons (Ellem, 2012).

Data collection methods

A face to face questionnaire will be used to obtain base line data from 50 study participants in the first instance and to provide a health profile of the study population (Appendix a). Following this, data from 10 individuals selected as cases will be collected using an interview guide to facilitate semi-structured interviews (Appendix b). This method of data collection is proposed as it allows for the examination of emerging themes rather than relying only on questions defined in advance of the interview (Silverman, 2010).

Population / sample

The target population of this study are statutory released offenders now living in the community. This population will be recruited from Staffordshire and West Midlands Probation Trust and will be accessed via their probation officers. The study will be introduced to participants by their probation officers in the first instance, and subsequently by the researcher to individuals who express an interest in participating in the study. The inclusion criteria for recruitment are:

- Participants must have been sentenced to between 2-8 years in prison and prior to release would have spent between 1-4 years in prison. These inclusion criteria was informed by the probation Trust which advised that these category of individuals were those who were most likely to have had a licence condition imposed on them which will require maintaining contact with the service for over six months after release
- Participants could be either male or female and must be above the age of 19 which will be their present age at recruitment if they had spent at least 1 year in prison and became imprisoned at 18 which is the age of legal responsibility in the UK.

Ethical considerations

The design and conduct of this study will be fully approved and monitored in accordance with the guidelines provided by The University of Wolverhampton School of Health and Wellbeing Ethics Committee. This study will also be underpinned by the University of Wolverhampton's Equal Opportunities policy and in line with the Data Protection Act 1998. The working practices and confidentiality requirements of all participating individuals will be fully respected and the anonymity of all participants in the research will be assured.

Confidentiality will be maintained by not divulging information to other personnel, except for those directly involved in the study, such as research supervisors and examiners. Such personnel will be unable to link the data to participants, as the data will be anonymised by using codes on the questionnaires and interview transcripts. Any quotes used in the research will use pseudonym rather than the participants' name. Data will be protected by keeping questionnaires, transcripts and interview

tape in a secure facility. Once the data has been examined, these will be destroyed. External hard drives and USB devices will be password protected. Audio recordings and transcripts will be stored in a secure and separate place from consent forms and personal information.

Approaches to participants will be made in a permanent form which offers an explanation of the purpose of the study and how the results will be used, an undertaking of anonymity and an assurance of the opportunity to withdraw at any time. Consent will be sought in writing. Permission will be sought from participants to use extracts from their data in the final thesis and in any academic publication. Individual participants may be able to recognise their own information; however, as far as possible, this information will be anonymised. Where participants disclose a crime or potentially dangerous thoughts which could cause harm to them or others, this would be immediately reported to their probation officers and the research officer of Staffordshire and West Midlands Probation Trust for appropriate action in line with Trust policy. Where individuals declare that they have been coerced to participate in the study, on making such disclosure they will immediately be excluded from the study.

It is not envisaged that this study will bring harm to participants. Nonetheless, where it is uncovered that this has occurred, such individuals will be immediately excluded from the study and offered appropriate help from the range of services provided by Staffordshire and West Midlands Probation Trust. Towards ensuring that the relevant ethical approval is got before commencing this study, in addition to seeking approval from the University of Wolverhampton School of Health and Wellbeing Ethics Committee, ethical approval will also be sought from the Ministry of Justice via the National Offender Management Service and Staffordshire and West Midlands Probation Trust.

Potential problems

Please see appendix d for the risk analysis of this research which is a standard template for potential risk to this research, not presumed to be exhaustive, but may be used as a guide to build upon.

Pilot Study

The questionnaires and interview guide to be used in this study will be piloted with a sample of released offenders and probation officers.

Analysis of Data

Data generated from administered questionnaires will be analysed using the scoring tool of the RAND 36-Item Short Form Health Survey 1.0. Only the General health subscale will be used and internal consistency reliability will be checked for all selected cases. Qualitative data generated from semi-structured interviews will be analysed thematically adopting a grounded theory approach (Strauss and Corbin, 1998) and using interview schedule questions to guide structure. These analyses will be supported by the use of participants verbatim quotations which will be assigned pseudonyms to ensure anonymity.

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Ethics application appendices

Appendix a: Data Collection Questionnaire

Process mapping the released offender health pathway Questionnaire

Part 1: Demographic details

1. Name
2. Date
3. Age
4. Sex
5. How will you describe your ethnicity
6. Is this your first sentence
7. How long was the sentence you were given and when will it finish?
Length of sentence
End date of sentence.....
8. When were you released into the community
9. What are you license conditions

10. Highest level of education

- a- Degree or equivalent
- b- Higher education or equivalent (below degree)
- c- GCE/GCSE A-levels or equivalent
- d- GCE/GCSE O-levels or equivalent
- e- Other qualifications at NVQ level 1 or below
- f- No formal qualifications

11. What is your employment status

- a- Paid/self- employed
- b- Unemployed
- c- Unemployed and looking for work
- d- Unable to work (long-term sickness/disability)
- e- Retired
- f- Looking after family or home
- g- In full-time education
- h- Doing something else

12. Are you on any form of benefits? If yes, what?

13. Are you homeless

14. Do you have a health condition

15. Are you registered with a GP

16. What is your marital status

17. Have you got any kids (how many)

Part 2: Health profile

1. In general, would you say your health is (rand, 1):

Excellent

Very good

Good

Fair

Poor

How TRUE or FALSE is each of the following statements for you?

2. I seem to get sick a little easier than other people (rand, 33).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

3. I am as healthy as anybody I know (rand, 34).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

4. I expect my health to get worse (rand, 35).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

5. My health is excellent (rand, 36).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

6. I have a health condition which affects my quality of life?

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

7. When I have a health need, I find it easy to see someone about my healthcare

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

8. I have difficulty accessing or registering with health services?

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

9. Access to nurses in the community in settings I visit for non-health needs has the potential to improve my uptake of health services

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

10. Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago

Somewhat better now than one year ago

About the same

Somewhat worse now than one year ago

Much worse now than one year ago

11. At present, if you need some health advise, where would you go?

Doctor/GP surgery

Walk in centre

Accident and Emergency

None of the above and hope the problem will go away

12. Would any of the following health promotion services be of use to you?

Drug/alcohol

Health eating/Health lifestyle

Sexual health awareness

Smoking cessation

Blood pressure/cholesterol checks

Any other? Please give details

13. If any of these were available, where would you like to access them? (prompt: GP surgery, health centre, pharmacy, probation office, job centre, place of worship)

Appendix b: Key Participant Interview Schedule

Process Mapping the Released Offender Health Pathway

Key Participant Interview Schedule for 1st Contact

March 2013

This research is funded by the Burdett Trust for Nursing and is aimed at mapping the released offender health pathway. As part of this study, I am obtaining the views of licensees on their use and engagement with health services in the community towards determining how nurses can lead the provision of health and social care interventions to released offenders in the community. You have been identified as someone whose views would be of value in this work. The purpose of the interview is to find out what health services you presently use and how you have used health services in the past. The interview takes around 1 hour, and will be held in a quiet space within the premises of Staffordshire and West Midlands Probation Trust.

Taping of Interview - Consent given [] Consent **not** given []

Name of key participant

Date

Part 1: Health Journey

1. Can you please describe your health?

2. Do you have a health condition which affects your quality of life? If yes, what level of support for this did you receive while in prison?

How have you been managing this on release? If no (2), if you had any health problem how would you manage this?

3. Have you encountered any barriers in accessing health services in the community and if so what are they?
4. Where and how do you pick up health information?
5. Has anyone in the Criminal Justice System ever tried to help you register with a GP?
6. When released from prison, what arrangements did the prison staff make for you with regards to accessing health service in the community?

Part 2: Use of Health Services

7. What health and social care service have you used in the community since leaving prison?
8. Since leaving prison, can you give me an example of a time when you received what you thought of as 'good healthcare' in the community? (Prompt: can you tell me what was 'good' about it, if necessary).
9. Since leaving prison, Can you give me an example of a time when you received what you thought of as 'poor healthcare' in the community? (Prompt: can you tell me what was 'poor' about it, if necessary).
10. Has engagement with the probation service influenced your health? (Prompt: what health help has your probation officer offered you since leaving prison?)
11. Is there anything that worries you about the potential consequences of using healthcare services

Part 3: Looking to the Future

12. What are your views on healthcare provision on release?
13. Excluding your health needs, what other needs do you have?
14. What is the biggest thing that will help you to avoid reoffending?
15. What do you think will make your health better?
16. What kind of health information will you like to access in the community and where would you like to access this information?
17. Is there anything else that is important to you that you would like to tell me about your health or the care that you would like to receive in the community

Thank you for your time and your help in this research. I hope in the near future I can feed back a summary of the findings of the research to all those who have participated. In the meantime, if you have any further questions or comments, please do not hesitate to contact me at the contact details below.

Cyril Eshareturi
01902 518644
Cyril.Eshareturi@wlv.ac.uk

Appendix c:
Key Participant Interview Guide for Contact after 1st Interview
March 2013

This research is funded by the Burdett Trust for Nursing and is aimed at mapping the released offender health pathway. As part of this study, I am obtaining the views of licencees on their use and engagement with health services in the community towards determining how nurses can lead the provision of health and social care interventions to released offenders in the community. You have been identified as someone whose views would be of value in this work. The purpose of the interview is to find out what health services you presently use and how you have used health services in the past. The interview takes 45 minutes, and will be held in a quiet space within the premises of Staffordshire and West Midlands Probation Trust.

Taping of Interview - Consent given [] Consent **not** given []

Name of key participant

Date

Mapping the Health Pathway

1. Can you describe your health in the last four weeks/since our last contact?
2. Since our last contact, can you briefly describe what your health journey has been? (Prompt: have you visited anywhere since our last contact with the intention of seeking help for your health condition?)
3. How did you find received services?
4. Since our last contact, have you picked up any new health information? If yes, where and how?
5. How has this information been useful to you?
6. Where would you consider as an ideal place where you would have liked to pick up this health information and why?
7. Since our last contact, where have you gone to get help in addressing your non-health needs?

Thank you for your time and your help in this research. I hope in the near future I can feed back a summary of the findings of the research to all those who have participated. In the meantime, if you have any further questions or comments, please do not hesitate to contact me at the contact details below.

Cyril Eshareturi
01902 518644
Cyril.Eshareturi@wlv.ac.uk

(Please note that the above is an interview guide and not a schedule. Accordingly, this is indicative but not exhaustive of the issues which will be explored during subsequent contacts. Importantly, interviews for subsequent contacts will be open ended and exploratory with the questions asked revolving around the issues uncovered in the interview conducted during all previous contacts)

Semi- structured interview with staff

At the conclusion of follow up of cases, interview transcripts will then be analysed to inform the results of this study. This analysis will also inform the questions to be asked to both health and social care service providers and members of staff which would subsequently inform the recommendations of this study.

Appendix d: Risk Analysis

The table below is a standard template for potential risks to this research, not presumed to be exhaustive, but may be used as a guide to build upon.

Risk	Assessment	Countermeasures and contingencies
Verbal or physical aggression to researcher	Likelihood: Low to Medium (All contact will be made in the premises of the Probation Trust)	Countermeasure: Researcher to enrol for a level 3 course on the management of actual or potential aggression
	Impact: Medium	Contingency plan: Involvement of individuals who have had no prior history of verbal or physical aggression within the premises of the Probation Trust
Slippage in scheduling of interviews	Likelihood: Medium to High (Interviews rescheduled to be held at a later time)	Countermeasure: Interviews planned to be held on the same day participants are required to visit their probation officer
	Impact: Medium (Impinge on progress of the research)	Contingency plan: Begin analysis of interviews already conducted and concurrently work on other aspects of the project such as analysis of questionnaires.
Technical difficulties in terms of computer software and Hardware	Likelihood: Low (up-to-date high quality hardware and software available in the University of Wolverhampton)	Countermeasure: Input data as soon as received and make multiple backup copies of files.
	Impact: High (analyses must then be achieved using sources which may compromise the integrity of data)	Contingency plan: Analyse data from one of multiple copies.
Project management issues	Likelihood: Low (I have prior experience in project management)	Countermeasure: Ensure clarification of all objectives and the 'manner and way' each objective will be achieved prior to the commencement of the research.
	Impact: Low	Contingency plan: Supervisors for guidance.
Operational issues: My illness and/or absence for unforeseen	Likelihood: Low	Countermeasure: Forward planning, deadline checks and regular meetings with supervisors

circumstances	Impact: Low	Contingency plan: To be agreed with supervisors
Operational issues: difficulty in recruiting participants	Likelihood: Medium	Countermeasure: Stress the aims and objectives of the research in user-friendly terms and emphasise the positive outcomes for participants in terms of improving services which would directly affect their quality of life
	Impact: High	Contingency Plan: Use large sample
Interviewees not responsive	Likelihood: Medium	Countermeasure: Prompt reminders and good diary keeping
	Impact: High	Contingency Plan: Contact other interviewees.

Appendix e: Participant Information Sheet

Study title

Process Mapping the Released Offender Health Pathway

Invitation paragraph

You are being invited to take part in a Burdett Trust funded study aimed at mapping the released offender health pathway. The Burdett Trust for Nursing is an independent charitable Trust which was established in 2002 with the aim of making charitable grants to support nursing contribution to healthcare. The Trustees target their grants at projects that are nurse-led and that empower nurses to make significant improvements to the patient care environment.

Before you decide, it is important that you understand why this research is being carried out and what your participation involves. Please take time to read the following information carefully, and discuss it with your probation officer if you wish. If anything is unclear or you would like more information about this research, please do not hesitate to ask.

What is the purpose of the study?

The purpose of this study is to map the released offender health pathway in order to identify 'touch points' in the community where nurse led interventions can be delivered.

Why have I been chosen?

You have been selected for inclusion in this study due to your license condition which indicates that you will be in touch with the probation service for over six months.

Do I have to take part?

- Participation is entirely voluntary
- This study has no connection with your license condition and will not influence your probation officers appraisal of you
- If you decide to take part you will be asked to sign a consent form

- You are free to withdraw at any time and without giving a reason
- Being involved or not taking part will not affect your current license condition at all

What will happen to me if I take part?

- You will be asked to fill a questionnaire in the first instance. This questionnaire is designed to collate your health profile to date
- Following this, if you are selected as a case, you will then be interviewed once every 4 weeks
- This interview will be an in-person (face-to-face) interview which will be done in a quiet office at the Trust, and will take no longer than 1 hour
- The interview will be scheduled to be held on the same day you have been scheduled to visit your probation officer
- The interview will be tape recorded to ensure that I capture all that you say
- You will be asked to sign an Informed Consent Form prior to the interview being conducted

How is confidentiality maintained?

- Data will be protected by keeping questionnaires, transcripts and interview tape in a secure facility
- Audio recordings and transcripts will be stored in a secure and separate place from consent forms and personal information
- Any quotes used in the research will use pseudonym rather than your name.
- Once the data has been examined, these will be destroyed
- External hard drives and USB devices will be password protected
- After the interview, I will listen to the recording and type up what was said – the interview will then be deleted from the audio-recorder
- What you say to me in the interview is completely confidential. This means that whatever is spoken about in the interview will not be communicated to other people except where you tell me that you, or someone else, are at risk of harm or danger. If this is the case, I will inform your probation officer about this

What are the possible benefits of taking part?

- This study has no affiliation to the NHS or CJS and cannot offer any health, social or legal help
- However, the benefits of taking part in this study are that you will have the opportunity to share your experience of the barriers you have faced in accessing health services on release and what you think can be done to improve this
- In addition, your views on the most appropriate locations for the delivery of nurse led interventions to released offenders in the community will also be sought

What will happen to the result of this study?

- The result of this research will be presented in a written report as a doctoral thesis and a copy of this will be handed over to the probation Trust and the Burdett Trust for Nursing
- All hard data will be stored in a locked filing cabinet at the University of Wolverhampton and electronically under secure password for 2 years in line with the Data Protection Act

Who has reviewed the study?

This study has been approved in accordance with the principles and procedures of the University of Wolverhampton School of Health and Wellbeing Ethics Committee, the National Offender Management Service Research Committee on behalf of the Ministry of Justice and Staffordshire and West Midlands Probation Trust.

What if something goes wrong?

At the end of the interview, if you feel upset or need further help or advice, or if there is anything about the research process you are unsure about; please let the researcher know who will then advise you on who you could contact.

What do I have to do?

If you decide to participate, please complete and return the enclosed/attached consent form to your probation officer.

Contact for further information

For further information, or to enquire about any aspect of this project, please contact in the first instance:

Cyril Eshareturi

Centre for Health and Social Care Improvement

School of Health and Wellbeing

University of Wolverhampton

Telephone: 01902 518644

E-mail: Cyril.Eshareturi@wlv.ac.uk

Thank you for taking the time to read this information.

Appendix f: Letter to Participants

Dear.....

I am writing to invite you to participate in a research designed to map the released offender health pathway. This research will be conducted by Cyril Eshareturi who is a doctoral student at the University of Wolverhampton. Enclosed herein is an information sheet, which explains the aims of the project and what will be expected of you if you decide to take part in this study.

If you are willing to be interviewed, the interviews will take no longer than 1 hour. Anything you say will be totally confidential and any notes made as a result of the interview would be destroyed afterwards. The interviews will take place in a quiet office at Staffordshire and West Midlands Probation Trust at a day and time that is convenient for you. A report will be written of the findings and pseudonyms will replace all names so that you cannot be identified.

If you feel that you would like to be interviewed, please let your probation officer know who will then facilitate a meeting between us. If you would prefer not to be involved, that is your choice as participation is entirely voluntary.

Yours sincerely,

Cyril Eshareturi

Doctoral Student

University of Wolverhampton

Centre for Health and Social Care Improvement

School of Health and Wellbeing

WV1 1DT

Tel: 01902518644

E-mail: Cyril.Eshareturi@wlv.ac.uk

Web: <http://www.wlv.ac.uk/chsci>

Appendix g: Informed Consent Form

Title of Project: Process Mapping the Released Offender Health Pathway

Name of Researcher: Cyril Esharehuri

If you are happy to participate in this research please complete and sign the consent form below, initialling each of the boxes to indicate you have understood what your participation entails.

1. I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

☐

3. I agree to take part in the above study.

☐

4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission.

☐

5. I agree for this interview to be tape recorded and for the anonymised data to be used for the purpose of this study.

☐

.....

Name

Date

Signature

.....

Researcher taking consent

Date

Signature

Appendix h: Consent form involving access to medical records and OASys-R

Title of Project: Process Mapping the Released Offender Health Pathway

Name of Researcher: Cyril Eshareturi

If you are happy to participate in this research please complete and sign the consent form below, initialling each of the boxes to indicate you have understood what your participation entails.

1. I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐
3. I understand that my medical records and OASys-R data being held by Staffordshire and West Midlands Probation Trust will be shared with the researcher of this study. I give permission for this researcher to have access to these records. ☐
4. I agree to take part in the above study ☐

.....
Name	Date	Signature
.....
Researcher taking consent	Date	Signature

Appendix i: Permission Letter

Cyril Eshareturi
Centre for Health and Social Care Improvement
School of Health and Wellbeing
University of Wolverhampton
Room ML117, Deanery Row
Wolverhampton
WV1 1DT
9th June 2013

Research Officer
Staffordshire and West Midlands Probation Trust
University Court
Staffordshire Technology Park
Beaconsfield, Stafford
ST18 0GE

Permission to conduct research within Staffordshire and West Midlands Probation Trust

Dear sir/madam,

I am a doctoral student at the University of Wolverhampton conducting a research entitled process mapping the released offender health pathway. This study is funded by the Burdett Trust for Nursing under the supervision of Prof Laura Serrant-Green, Dr Victoria Galbraith and Dr Martin Glynn.

The aim of this study is to map the released offender health pathway in order to identify points in the community where nurse led interventions can be delivered to these individuals towards addressing their health and social care needs. I am hereby seeking your consent to recruit my sample from Staffordshire and West Midlands Probation Trust.

I have provided you with a copy of my ethics application to both the University of Wolverhampton and the National Offender Management Service, as well as copies of the approval letter which was received from both organisations.

Upon completion of the study, I undertake to provide Staffordshire and West Midlands Probation Trust a bound copy of the full research report. If you require any further information, please do not hesitate to contact me on:

Tel: +44 (0)1902 518644

Fax: +44 (0)1902 321161

E-mail: Cyril.Esharehuri@wlv.ac.uk

Thank you for your time and consideration in this matter.

Yours sincerely,

Cyril Esharehuri.

Appendix II: Ethics approval letters



HP/EH

12th June 2013

Mr Cyril Eshareturi
University of Wolverhampton
Centre for Health and Social Care Improvement
ML117
Deanery Row, Off Molineux Street,
Wolverhampton

Dear Cyril,

Re: "Process Mapping the Released Offender Health Pathway "

The School of Health and Wellbeing Ethics Sub-Committee Board met on 10th June 2013 Your project was approved without amendments, and you now may proceed with this study.

It was agreed for your project to be awarded the following Codes.

University Category: A1- Favourable

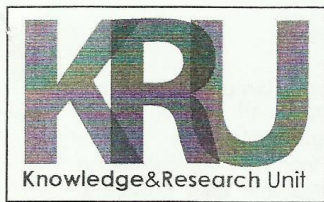
I would like to wish you every success with the project.

Yours sincerely

H Paniagua

H Paniagua

Dr H Paniagua PhD MSc, BSc (Hons) Cert. Ed. RN RM
Chair – School Ethics Committee



Staffordshire and
West Midlands
Probation Trust



Cyrl

R4 STAFFORDSHIRE AND WEST MIDLANDS PROBATION TRUST

Research and Information Sharing Agreement

1. This Agreement

- 1.1. This agreement is between Cyril Eshareturi, Doctoral Student, Centre for Health and Social Improvement, School of Health and Wellbeing, University of Wolverhampton WV1 1DT and Staffordshire and West Midlands Probation Trust (SWMP) based at 2nd Floor, 5 St Philip's Place, Colmore Row, Birmingham B3 2PW.

hereafter referred to as the Parties.

- 1.2. The purpose of the agreement is to allow the sharing between the Parties of personal data that is subject to the provisions of the Data Protection Act 1998 and to agree what is required of each party in respect of:

- Trust support from Staffordshire and West Midlands Probation Trust to the individual or organisation
- Trust arrangements for providing access to sample data
- Production and approval of the research report or dissertation.
- Information sharing

2. Delivery Unit Support

- 2.1 Local Delivery or Information Unit or partnership to complete as appropriate

- Jamie-Ann Edwards, Local Delivery Unit Head, Walsall (Staffordshire and West Midlands Probation Trust).
- Record approval for research work obtained at appropriate level
- Sample data details from the Business Transformation Unit..
- Phil Massey , Research Officer, Business Transformation Unit

- Time frame for the work (from IRAS form) – start date 1st October 2012, data collection 1st August 2013 to 1st April 2014 and report completion date 1st October August 2015.
- Primary use of office space at Midland Road, Walsall - probation resources required – office, staff time and data providers. There will required use of probation premises at Midland Road to facilitate scoping of sample list to assist client interviews. Team meetings and other appointments will be also help the researcher move the proposal forward with probation staff.

3. Arrangements for Providing Access to Sample Data

- 3.1 The named Trust officer will provide the approved information from Delius, EOASys, CRAMS or paper files. The information may be provided in either electronic or hard copy as appropriate. The researchers can not have direct access to I.T systems and can only access a list of approved files under supervision. If access to IT is required a separate application will need to be prepared and submitted for approval by the Executive Team.

4. Production and Approval of Research Report or Dissertation

- 4.1 An agreed final date for submission of the draft report the Trust will be set out in the agreement, this will be six weeks prior to submission to any university, other organisation or publication. The Trust Research Officer will ensure that formal approval from the Executive Team (or delegated officer) for release of the information is obtained from the Trust prior to submission to an education establishment or publication. The Research Officer will also ensure that the PR department is aware of the status of the report. Any slippage on expected dates (or abandonment of the project) will also need to be reported to the Executive Team.

The original aim is that the research will be completed by the 1st October 2015 and a summary provided to NOMS.

- 4.2 The Research Officer will ensure in the request to the Executive Team for formal approval/release of information an agreed date for publication or submission to an education establishment
- 4.3 SWMP reserves the right to refuse to allow any data or results connected with Staffordshire and West Midlands Probation Trust to be used if the researcher has not adhered to the approved methodology.
- 4.4 The approved research proposal or methodology may not be altered without written permission from the Research Officer.

5. Area Information Sharing Agreement

- 5.1. The parties agree to share the personal data specified below for the purposes of research

"The aim of this research will be:

1. To map the released offender health pathway towards identifying 'touch points' in the community where nurse led interventions can be delivered
2. To describe and explain the offender health journey on release of the offender from prison into the community
3. To explore and document current levels of support aimed at improving the health of released offenders in the community
4. To gather, describe, interpret and understand the views, opinions and lived experiences of released offenders in the context of their uptake of health services in the community
5. To evidence the opinion of individuals who have been in contact with released offenders with regards to released offender uptake of health services in the community:
 - a. Prison staff
 - b. Probation officers
 - c. Nurses
 - d. Social workers
 - e. NGO support staff who currently interface with recently released offenders
6. To develop a document containing recommendations for practice on how nurses can contribute to providing health care for released offenders in the community.

The research will adopt the use of a questionnaire as a source of baseline data in providing the general health profile of 50 research participants. This will then be ranked on the basis of poor health with the 5 top ranking individuals of either gender (5 male and 5 female) selected as cases to be followed up prospectively for six months.

A face to face questionnaire will be used to obtain base line data from 50 study participants in the first instance and to provide a health profile of the study population. Following this, data from 10 individuals selected as cases will be collected using an interview guide to facilitate semi-structured interviews.

5.2 The legislation or regulation that permits information sharing activities within this project includes:

- Criminal Justice and Court Services Act 2000 ss67 and 68,
- Crime and Disorder Act 1998, s115,
- Data protection Act s33.

5.3 The parties to this agreement confirm that they will share and process the following categories of personal data:

- Offender details – name, date of birth, ethnicity, gender, address. Personal data required will be limited in that names of participants will not be required.
- OASys, including risk screening and full risk of harm where applicable
- Attendance in accordance with National Standards and enforcement where applicable.

5.4. The parties to this agreement confirm that their processing of the personal data to be shared complies with the requirements of Schedule 2 of the Data Protection Act 1998, and that the processing of personal data meets one of the following conditions:

- Consent of the data subject
- Processing is necessary for a contract to which the data subject is party
- Processing is necessary for compliance with the data controller's legal obligation
- Processing is necessary for the administration of justice
- Processing is necessary to satisfy the legitimate interests of the data controller and/or a third party, except where the processing is

unwarranted by reason of prejudice to the rights and freedoms of the data subject.

5.5 The parties to this agreement confirm that they will share and process the following sensitive personal data:

- Racial/ethnic origin of the data subject;
- His/her physical or mental health or condition;
- The commission or alleged commission by the data subject of an offence and any related proceedings;

5.6 The parties to this agreement confirm that their processing of sensitive personal data, as identified in paragraph 5 above, to be shared complies with the requirements of Schedule 3 of the Data Protection Act 1998, and that the processing of this sensitive personal data meets one of the following conditions:

- Explicit consent of the data subject;
- Processing is by a not-for-profit organisation and has safeguards to protect the rights and freedoms of individuals;
- Processing is necessary for legal proceedings;
- Processing is necessary for the administration of justice, for the exercise of functions conferred by enactment;
- Processing is necessary for medical purposes, undertaken by a health professional;
- Processing is of racial/ethnic origin data and is necessary to monitor equality of opportunity;
- Processing is specified by order of the Secretary of State.

5.7 The persons authorised by this agreement to send and receive the relevant personal data are:

Authorised staff (or staff groups)	Classes of data to be shared	Method of transmission of data (specify: electronic, or hardcopy; or state "All")	Authorised to "Send", / "Receive", or "Both"
---------------------------------------	---------------------------------------	--	---

Researcher – Cyril Esharehuri Cyril.Esharehuri@wlv.ac.uk	Restricted	Electronic/hardcopy/all	Both
--	------------	-------------------------	------

The email address of the researcher is not a secure GSI address so alternative arrangements will need to be in place so offender data/information can be shared.

5.8. Data will be protected by keeping questionnaires, transcripts and interview tapes in a secure facility located within the Centre for Health and Social Care Improvement in the University of Wolverhampton. Once the data has been examined, these will be destroyed. External hard drives and USB devices will be password protected. Audio recordings and transcripts will be stored in a secure and separate place from consent forms and personal information.

Personal data will be anonymised by using codes on the questionnaires and interview transcripts. Any quotes used in the reporting of findings will use pseudonym rather than the participant's name. Importantly, the findings of this study will be presented thematically in order to avoid unwittingly disclosing the identities of research participants.

All electronically held data will be disposed using a data erasing software. Paper held data will be disposed using a paper shredder. The data will be retained for a period of 3 years from the date of collection.

5.9 Where data is to be sent electronically between the parties, this agreement must specify:

- The interface boundary between the parties' respective networks, if applicable;
- The method of connection between the respective networks;
- Clear delineation of responsibilities at the interface boundary or point of data exchange.

See secure email note on 5.7

5.10. The parties to this agreement are required to:

- append to this agreement a copy of their respective current notifications to the Information Commissioner, to confirm that they are permitted to process personal data as required by this agreement;
- **where individual identifiable information is being shared inform data subjects in writing (copy of notice to be attached to this agreement) that their personal data is shared within the terms of this agreement;**
- to obtain explicit consent of the data subject where this is required (copy of consent form to be attached to this agreement);
- ensure that all staff who implement the terms of this agreement are aware of the requirements of the agreement;
- ensure that all data received as a function of this agreement is stored securely, is not accessible to unauthorised persons, is not altered, lost or destroyed, and is retrieved only by properly authorised persons;
- comply with the BS7799 standard for the management of information security;
- Jointly review the operation of this agreement to ensure data is not retained longer than necessary.

5.11 If any party to this agreement becomes aware of a security breach, or breach of confidence in relation to the data covered by this agreement, or breach of the terms of this agreement, the party with responsibility for the area of activity in which the breach occurred, shall:

- immediately inform other parties to this agreement that a breach has occurred;
- immediately investigate the cause, effect and extent of the breach;
- report the results of the investigation to the other party, without delay;
- Use all reasonable efforts to rectify the cause of such breach.
- Take any necessary immediate action e.g. initiate relevant HR procedures, suspend research

5.12. Each party will ensure that all staff implementing this agreement are made aware that the disclosure of personal information without consent must be justifiable on statutory grounds, or meet the criterion for claiming an exemption under the Data Protection Act 1998. Without such justification, both the agency and the member of staff expose themselves to the risk of prosecution and liability to a compensation order under the Data Protection Act 1998, or damages for a breach of the Human Rights Act 2000.

5.13 The data controllers for the parties to this agreement are:

STAFFORDSHIRE AND WEST MIDLANDS PROBATION TRUST JAMIE-ANN EDWARDS

Name of Researchers

CYRIL ESHARETURI

(Signature)

07-01-14

5.14. The data protection officers for the parties to this agreement are:

STAFFORDSHIRE AND WEST MIDLANDS
PROBATION TRUST &
WOLVERHAMPTON UNIVERSITY

Name of Researchers

Name of officers (JAMIE-ANN
EDWARDS)

CYRIL ESHARETURI

(Signature)

07-01-14

5.15 The representatives of the parties to this agreement are:

STAFFORDSHIRE AND WEST
MIDLANDS PROBATION TRUST
JAMIE-ANN EDWARDS, LDU
Head Walsall

Signature:

Jamie Edwards
8.1.14

Name of Researchers

CYRIL ESHARETURI

Date agreement signed

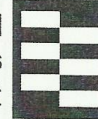
Cyril Eshareturi

Signature:

07.01.14

P.E. Masson
Research Officer 7-1-14.

Staffordshire and
West Midlands
Probation Trust



R5 Confidentiality Agreement

This agreement made on 7 January 2014 is between Cyril Eshareturi, Wolverhampton University and Staffordshire and West Midlands Probation Trust.

The purpose of this agreement is to allow the sharing between the Parties named above of personal data that is subject to the provisions of the Data Protection Act 1998.

In working with the Staffordshire and West Midlands Probation Trust you may have access to personal and sensitive business information (personal data – refers to Personal Information relating to a Data Subject's race or ethnic origin, political opinions, religious belief, trade union membership, physical and mental health or condition, sexual life and any alleged or actual criminal activities or criminal record), which may be held in electronic form, or on paper or similar hardcopy, or may be spoken in face to face or telephone conversations.

The personal information held by the National Probation Service (NPS) is subject both to the common law duty of confidentiality (i.e. where the information is not a matter of public knowledge, and is entrusted by an individual in confidence where there is general obligation not to disclose the information without consent), and to the Data Protection Act 1998 which provides for the protection of personal information.

In signing a copy of this form you are acknowledging that you have duties in law (for example under the term of the Data Protection Act 1998 and Freedom of Information Act 2000) to ensure that you do not misuse any such information, or pass it to any unauthorised person outside or within the Staffordshire and West Midlands Probation Trust, or attempt to alter or otherwise process such information, without the clear direction of an NPS employee.

You may be liable to legal action and to possible criminal proceedings if you do not comply with the expectations set out in this agreement.

1 **Purpose of Research**

The parties agree to share the personal data specified below for the purposes of:

1. To map the released offender health pathway towards identifying 'touch points' in the community where nurse led interventions can be delivered
2. To describe and explain the offender health journey on release of the offender from prison into the community
3. To explore and document current levels of support aimed at improving the health of released offenders in the community
4. To gather, describe, interpret and understand the views, opinions and lived experiences of released offenders in the context of their uptake of health services in the community
5. To evidence the opinion of individuals who have been in contact with released offenders with regards to released offender uptake of health services in the community:
 - a. Prison staff
 - b. Probation officers
 - c. Nurses
 - d. Social workers
 - e. NGO support staff who currently interface with recently released offenders
6. To develop a document containing recommendations for practice on how nurses can contribute to providing health care for released offenders in the community.

The parties receiving this information may not use the personal data for any other purpose than that stated above.

2 **Personal Data Categories**

The parties to this agreement confirm that they will share and process the following categories of personal data;

- Offender details – name, date of birth, ethnicity, gender, address
Personal data required will be limited in that names of participants will not be required.
- OASys, including risk screening and full risk of harm where applicable
- Attendance in accordance with National Standards and enforcement where applicable

3 **Use of Data**

The parties to this agreement confirm that their processing of the personal data to be shared complies with the requirements of Schedule 2 of the Data Protection Act 1998, and that the processing of personal data meets one of the following conditions: (*tick as applicable*)

- ☒ X Informed consent of the data subject obtained in writing
- ☒ X Processing is necessary to satisfy the legitimate interests of NPS West Midlands (the data controller) and/or a third party, except where the processing is unwarranted by reason of prejudice to the rights and freedoms of the data subject.

4. Information which must not be shared with researchers;

Police Antecedents

Copies of official police antecedents are supplied to the Probation Area in confidence and are not the property of the Probation Area to disclose.

Core information concerning an offender's criminal history will **if necessary for the research purpose**, be shared through the OASys document.

5. Data Retention

All electronically held data will be disposed using a data erasing software. Paper held data will be disposed using a paper shredder. The data will be retained for a period of 3 years from the date of collection.

Audio recordings and transcripts will be stored in a secure and separate place from consent forms and personal information.

6 Electronic Transmission of Data

Where data is to be sent electronically between the parties, this agreement must specify the relevant addresses; e.g. GSI /GSX / secure e mail a/c.

Personal data must not be transmitted via an unsecured e mail account.

Sender	Cyril.Esharehuri@wlv.ac.uk
Recipient	<<insert e mail address>>

The email address of the researcher is not a secure GSI address so alternative arrangements will need to be in place so offender data/ information can be shared.

Only encrypted memory sticks supplied by Steria (SWMPTs IT provider) are allowed to be used on SWMPTs PCs and laptops.

Any data to be carried or stored away from SWMPT premises must also be on these memory sticks purchased from Steria NOT on laptops, discs or personal memory sticks.

7 Specific Requirements;

The parties to this agreement are required to:

- to obtain explicit consent of the data subject (<<copy of consent form to be attached to this agreement>>);
- ensure that all staff who implement the terms of this agreement are aware of the requirements of the agreement;
- ensure that all data received as a function of this agreement is stored securely, is not accessible to unauthorised persons, is not

UNCLASSIFIED

altered, lost or destroyed, and is retrieved only by properly authorised persons;

8 Breaches of Security


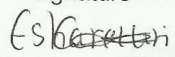
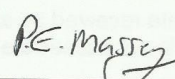
If any party to this agreement becomes aware of a security breach, or breach of confidence in relation to the data covered by this agreement, or breach of the terms of this agreement, the party shall:

- immediately inform other parties to this agreement that a breach has occurred;
- immediately inform the Staffordshire and West Midlands Probation Trust Risk Manager (0121 634 1321) and Staffordshire and West Midlands Probation Trust IT Support & Training Manager (0121 634 2350)
- immediately investigate the cause, effect and extent of the breach;
- report the results of the investigation to the other party, without delay;
- use all reasonable efforts to rectify the cause of such breach and prevent further disclosures.

9 Termination

Either party shall be entitled by written notice to the other to terminate this Agreement either immediately or as from the date specified in such notice. If the other party is guilty of any breach of the provisions of this Agreement and such breach if capable of remedy is not remedied within twenty working days of written notice to that effect.

10 The representatives of the parties to this agreement are:

SWMPT Designated Senior Manager	Jamie-Ann Edwards LDU Head	I have read, understand and agree to comply with this agreement; <<signature >> 	Date 7 January 2014
<<Researcher>> University of Wolverhampton	Cyril Eshareturi	I have read, understand and agree to comply with this agreement; <<signature >>  07.01.14  P.E. Maguire Research Officer 7-1-14	Date 7 January 2014

Research 5/Confidentiality Agreement/October 2012

Appendix III: Search strategy

Searching Electronic Databases

The electronic gateway of the University of Wolverhampton was accessed. From thereon, access to the subject starting point of Health and Well Being, Social Sciences, Humanities and Legal Studies was gained. Subsequent to the identification of all relevant databases, a thorough electronic literature search was conducted. In carrying out the database search, the NHS Core Collection, SocINDEX, Swetswise, ASSIA, JSTOR, IBSS, ScienceDirect, INGENTA, ISI Web of Knowledge, West Law UK, Lexis Library, Google Scholar, SuperSearch, Proquest, EbscoHost and the British Humanities Index were useful, as they afforded the opportunity to search numerous journals simultaneously.

Selection of Keywords

Based on the broad scan and material gotten therein, search keywords were determined. These were: 'Offender Health', 'Prisoner Health' 'Ex-offender Health' 'Offender Re-entry', 'Ex-offender Integration' and Ex-offender Continuity of Care. Synonyms were also identified, using the thesaurus, as advised in the help section of the Dialog Data Star provided by the University of Wolverhampton Electronic Platform.

Keywords Used

The keywords used were selected based on an initial survey of current literature, as well as prior knowledge of the area. However, it should be noted that the process of identifying literature was an iterative one which needed to be repeated and refined as the search progressed. Thus, the eventual search terms used were:

Offender OR Prisoner OR Ex-offender OR Ex-prisoner OR Offender Health OR Prisoner Health OR Ex-offender health OR Ex-prisoner Health OR Continuity of Care.

In various combinations with:

NHS, UK Government, England, England and Wales, Nurses, Urgent Care, Primary Care, Health Interventions, Probation, Health and Social Care, Commissioning, Re-entry, Continuity of access, Reintegration and Nursing

Mostly, the Boolean Operator AND was used between words/phrases in these combinations.

Entering Search Terms into Databases

Search terms were mostly entered on separate search lines in the *Easy Search* mode and connected by the Boolean operators (AND, OR, WITH, NEAR and XOR) as shown earlier, with the search terms being placed within parenthesis. The *Advanced Search* mode was utilized when too many hits were obtained, or when a complex combination of various results from the easy search was required. Additionally, to limit truncation the '\$' symbol was used as a wild card. Thus for example, the word '*OFFENDE\$*' was used to retrieve all related words beginning with the same stem word as 'offender', this was done to include offender and offending in the search.

Search Results

An initial combination of the search terms yielded above 3,000 hits. However, not all hits were relevant to this study. Consequently, the search was modified further and the results skimmed to exclude irrelevant materials. The main criterion for

determining what counted as good evidence was the broad view of 'fitness for purpose' as explained in Nutley, Walter and Davies (2007).

Inclusion criteria: In English, published between; 1990 - 2015. However, other relevant materials, which did not fall within these years, were also included when they happened to be retrieved.

Exclusion criteria: Not in English, this was due to my inability to read text written in any other languages.

Snowballing

Electronic search was predominantly used to retrieve relevant papers. Unavoidably however, a few important papers would have been missed if this was the only strategy employed (Lipsey and Wilson, 2001). Therefore, to identify and retrieve missed papers, Glasziou *et al.* (2001) recommend the snowballing approach. Accordingly and where appropriate, the bibliographies of some accessed papers were inspected to locate other relevant studies. In addition, using the Science Citation Index available at www.isinet.com, a citation search was performed. These two strategies of snowballing, referred to as *ancestor search* and *descendant search* respectively (DeCoster 2004, p.9), yielded additional studies which were initially missed during the electronic search.

Hand Searching of Journals

As the research papers were retrieved and examined, it became increasingly clear that certain journals aimed to publish papers which revolve around offenders and the criminal justice system and therefore; published a great number of relevant studies. Accordingly, the formal literature search was complemented by a search through relevant journals and websites to identify articles that may have been missed in the

database search. Thus, using the University of Wolverhampton's OPAC system, Google Scholar and Google search engine, the indices and table of contents of the following relevant journals were hand-searched:

1. International Journal of Offender Therapy and Comparative Criminology
2. Prison Reform Trust
3. Revolving Door Agency
4. Journal of Nursing Scholarship
5. Psychology, Crime and Law
6. Journal of Urban Health
7. Trends and Issues in Crime and Criminal Justice
8. British Journal of Community Nursing
9. Criminal Behaviour and Mental Health
10. Corrections Forum
11. Sainsbury Centre
12. Centre for Crime and Justice Studies
13. International Journal of Prisoner Health

Searching Grey Literature

According to Rumsey (2004), The term 'grey' literature is used to denote publications that are not easily identified nor accessed via the usual sources, such as books, journals, or where publishing is not the primary activity of the organization. In this case, these included conference proceedings, newspaper reports, organisational official publications, as well as research papers prior to publication. Google and Yahoo were employed as search engines utilized to retrieve grey literature relevant to this study.

Appendix IV: Administered questionnaire

Name:

Date:

Part 1: Health profile

1. In general, would you say your health is (rand, 1):

Excellent

Very good

Good

Fair

Poor

How TRUE or FALSE is each of the following statements for you?

2. I seem to get sick a little easier than other people (rand, 33).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

3. I am as healthy as anybody I know (rand, 34).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

4. I expect my health to get worse (rand, 35).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

5. My health is excellent (rand, 36).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

6. I have a health condition which affects my quality of life?

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

7. When I have a health need, I find it easy to see someone about my healthcare

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

8. I have difficulty accessing or registering with health services?

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

9. Access to nurses in the community in settings I visit for non-health needs has the potential to improve my uptake of health services

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

10. Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago

Somewhat better now than one year ago

About the same

Somewhat worse now than one year ago

Much worse now than one year ago

11. At present, if you need some health advice, where would you go?

Doctor/GP surgery

Walk in centre

Accident and Emergency

None of the above and hope the problem will go away

12. Would any of the following health promotion services be of use to you?

Drug/alcohol

Health eating/Health lifestyle

Sexual health awareness

Smoking cessation

Blood pressure/cholesterol checks

Any other? Please give details

13. Have you got anything else that you would like to share with me

Part 2: Demographic details

14. Highest level of education

- a- Degree or equivalent
- b- Higher education or equivalent (below degree)
- c- GCE/GCSE A-levels or equivalent
- d- GCE/GCSE O-levels or equivalent
- e- Other qualifications at NVQ level 1 or below
- f- No formal qualifications

15. What is your employment status

- a- Paid/self- employed
- b- Unemployed
- c- Unemployed and looking for work
- d- Unable to work (long-term sickness/disability)
- e- Retired
- f- Looking after family or home
- g- In full-time education
- h- Doing something else

16. Are you on any form of benefits? If yes, what?

17. Are you homeless

18. Are you registered with a GP

19. What is your marital status

20. Have you got any kids (how many)

Appendix V: Rand scoring tool

Scoring tool for general health scale of the RAND 36-Item short form health survey 1.0

STEP 1: SCORING QUESTIONS:

ITEM NUMBERS	ORIGINAL RESPONSE	RECORDED VALUE
1, 2, 20, 22, 34, 36	1	100
	2	75
	3	50
	4	25
	5	0
ITEM NUMBERS	ORIGINAL RESPONSE	RECORDED VALUE
3, 4, 5, 6, 7, 8, 9, 10, 11, 12	1	0
	2	50
	3	100
ITEM NUMBERS	ORIGINAL RESPONSE	RECORDED VALUE
13, 14, 15, 16, 17, 18, 19	1	0
	2	100
ITEM NUMBERS	ORIGINAL RESPONSE	RECORDED VALUE
21, 23, 26, 27, 30	1	100

	2	80
	3	60
	4	40
	5	20
	6	0

ITEM NUMBERS	ORIGINAL RESPONSE	RECORDED VALUE
24, 25, 28, 29, 31	1	0
	2	20
	3	40
	4	60
	5	80
	6	100

ITEM NUMBERS	ORIGINAL RESPONSE	RECORDED VALUE
32, 33, 35	1	0
	2	25
	3	50
	4	75
	5	100

STEP 2: AVERAGING ITEMS TO FORM 8 SCALES:

SCALE	NUMBER OF ITEMS	AFTER RECORDING SCORES PER TABLE 1, AVERAGE THE FOLLOWING ITEMS
Physical functioning	10	3, 4, 5, 6, 7, 8, 9, 10, 11, 12
Role limitations due to physical health	4	13, 14, 15, 16
Role limitations due to emotional problems	3	17, 18, 19
Energy/ fatigue	4	23, 27, 29, 31
Emotional well being	5	24, 25, 26, 28, 30
Social functioning	2	20, 32
Pain	2	21, 22
General health	5	1, 33, 34, 35, 36

STEP 3: FIGURING SCORES:

RAND recommends the following straightforward approach to scoring the RAND 36-Item Health Survey.

All questions are scored on a scale from 0 to 100, with 100 representing the highest level of functioning possible. Aggregate scores are compiled as a percentage of the total points possible, using the RAND scoring table (STEP I chart).

The scores from those questions that address each specific area of functional health status (STEP II chart) are then averaged together, for a final score within each of the 8 dimensions measured. (eg pain, physical functioning etc.)

For example, to measure the patient's energy/fatigue level, add the scores from questions 23, 27, 29, and 31. If a patient circled 4 on 23, 3 on 27, 3 on 29 and left 31 blank, use table 1 to score them.

An answer of 4 to Q23 is scored as 40, 3 to Q27 is scored as 60, and 3 to Q29 is scored as 40. Q31 is omitted. The score for this block is $40+60+40=140$. Now we divide by the 3 answered questions to get a total of 46.7. Since a score of 100 represents high energy with no fatigue, the lower score of 46.7% suggests the patient is experiencing a loss of energy and is experiencing some fatigue.

All 8 categories are scored in the same way. Using this questionnaire at the beginning and during the course of care, we can track the progress of the 8 parameters mentioned in the STEP II chart.

Appendix VI: Ranked scores

S/NO	Name	Scores	Ranked	Position	Internal Validity
01	DW	75, 100, 100, 100, 75	90		No
02	RA	75, 100, 100, 25, 75	75		NO
03	CC	25, 25, 25, 100, 0	35	5	YES
04	GT	75, 75, 50, 100, 75	75		NO
05	BR	50, 25, 100, 0, 25	40	6	YES
06	NA	75, 100, 100, 100, 75	90		NO
07	SK	25, 0, 25, 0, 0	10	1	YES
08	SA	75, 75, 75, 75, 75	75		NO
09	PB	100, 25, 75, 100, 100	80		NO
10	RM	50, 100, 75, 50, 75	70		NO
11	LMI	0, 0, 0, 100, 25	25	4	YES
12	RJ	100, 100, 100, 75, 100	95		NO
13	JT	75, 100, 100, 100, 75	90		NO
14	DH	25, 50, 0, 0, 25	20	3	YES
15	SP	75, 75, 25, 50, 25	50	7	YES
16	AS	50, 50, 75, 100, 75	70		NO
17	CR	100, 75, 75, 100, 75	85		NO
18	AF	75, 100, 75, 25, 75	70		NO
19	AM	75, 100, 75, 75, 75	80		NO
20	NH	25, 25, 25, 0, 0	15	2	YES
21	DJ	75, 100, 100, 0, 100	75		NO
22	CN	50, 100, 100, 75, 75	80		NO
23	PH	100, 100, 100, 100, 100	100		NO
24	PB	75, 25, 75, 75, 75	65		NO
25	SK	100, 100, 100, 100, 100	100		NO
26	AR	25, 0, 0, 100, 25	30	8	YES

Appendix VII: Semi-structure interview of cases at 1st month

Key Participant Interview Schedule

Process Mapping the Released Offender Health Pathway

Key Participant Interview Schedule for 1st Contact

March 2013

This research is funded by the Burdett Trust for Nursing and is aimed at mapping the released offender health pathway. As part of this study, I am obtaining the views of licensees on their use and engagement with health services in the community towards determining how nurses can lead the provision of health and social care interventions to released offenders in the community. You have been identified as someone whose views would be of value in this work. The purpose of the interview is to find out what health services you presently use and how you have used health services in the past. The interview takes around 1 hour, and will be held in a quiet space within the premises of Staffordshire and West Midlands Probation Trust.

Taping of Interview - Consent given [] Consent **not** given []

Name of key participant

Date

Part 1: Health Journey

1. Please describe the health condition which affects your quality of life and the level of support you received for this while in prison?
2. How have you been managing this in the community?
3. Have you encountered any barriers in accessing health services in the community and if so what are they?
4. Has anyone in the Criminal Justice System ever tried to help you register with a GP?
5. On release from prison, what arrangements did the prison staff make for you with regards to accessing health service in the community?

Part 2: Use of Health Services

6. What health and social care service have you used in the community since leaving prison?
7. Since leaving prison, can you give me an example of a time when you received what you thought of as 'good healthcare' in the community? (Prompt: can you tell me what was 'good' about it, if necessary).
8. Since leaving prison, Can you give me an example of a time when you received what you thought of as 'poor healthcare' in the community? (Prompt: can you tell me what was 'poor' about it, if necessary).
9. Has engagement with the probation service influenced your health? (Prompt: what health help has your probation officer offered you since leaving prison?)
10. Is there anything that worries you about the potential consequences of using healthcare services

Part 3: Looking to the Future

11. What are your views on healthcare provision on release?
12. Excluding your health needs, what other needs do you have?
13. What is the biggest thing that will help you to avoid reoffending?
14. What do you think will make your health better?
15. What kind of health information will you like to access in the community and where would you like to access this information?
16. Is there anything else that is important to you that you would like to tell me about your health or the care that you would like to receive in the community

Thank you for your time and your help in this research. I hope in the near future I can feed back a summary of the findings of the research to all those who have participated. In the meantime, if you have any further questions or comments, please do not hesitate to contact me at the contact details below.

Cyril Eshareturi
01902 518644
Cyril.Eshareturi@wlv.ac.uk

Appendix VIII: Semi-structure interview with cases at 6th month

SSI Questions for participants at the 6th month of follow up

- How can we make healthcare accessible for people coming out of prisons?
- Some participants have suggested a nursing appointment service at the probation service to facilitate nurse led assistance. What are your thoughts on this?
- A drop in centre led by nurses at the probation service has being suggested? What are your thoughts on this?
- Which would you prefer?
- Would an open evening for health issues led by a nurse be useful? If yes, where would be the ideal location to provide such a service?
- Do you envisage any problem with your probation officer arising as a consequence of disclosing your health issues?
- How do you propose for this to work with regards to confidentiality?
- Some people have said managing re-entry into the community was a big problem. How did you manage it?
- A major theme was the lack of pre-release support with regards to health when leaving prison. What are your thoughts on this?
- Some people indicated that they were never asked if they had a GP on release from prison. What was your experience?

- What are your thoughts on the relationship between probation in prison and probation outside prison?
- Family support was identified in helping individuals integrate on release and access health services. How did this affect you?
- So what questions would you like me to ask the Probation Officers? What would you like answers to that perhaps ordinarily you're not getting answers to or you think they should be doing more towards that?

Appendix IX: Semi-structure interview with collective voices

Key Participant Interview Guide for Collective Voices

December 2014

This research is funded by the Burdett Trust for Nursing and is aimed at mapping the released offender health pathway. As part of this study, I am obtaining the views of licencees on their use and engagement with health services in the community towards determining how nurses can lead the provision of health and social care interventions for released offenders in the community. You have been identified as someone whose views would be of value to this work. The purpose of the interview is to elicit your views on the provision of a nurse-led intervention for ex-offenders in order to add, corroborate or refute some of the issues uncovered in the interviews conducted with ex-offenders. The interview takes 25 minutes, and will be held in a quiet space within the premises of Staffordshire and West Midlands Probation Trust.

Taping of Interview - Consent given [] Consent **not** given []

Name of key participant

Date

Collective Voices Interview Guide

1. What are your thoughts on the pre-release support received by offenders in preparation for accessing health services on release?
2. The participants interviewed maintain that the probation trust would be an ideal location for the provision of a nurse-led service. What are your thoughts on this?
3. If we did decide to provide a nurse led service, would you prefer the service to be provided on an appointment basis or as a drop in centre and why?
4. How would you recommend a nurse-led service operate with regards to data protection?
5. Participants recommend that any provided service should operate on an advisory level as a sign-posting service. What are your thoughts on this?
6. Participants recommend that an open evening around health issues would be hugely beneficial. What are your thoughts on this?
7. Family support was found to be crucial in helping individual's access health services on release. In cases where individuals do not have this support, what in your experience have you observed has been helpful to them?
8. Participants recommend that probation officers do more in helping them find a GP in the community. What are your thoughts on this?
9. Participants recommend that probation officers get in touch with them in person in prison prior to release. What are your thoughts on this?
10. Who else can you recommend I speak to? An individual in your opinion you think their expertise could inform the outputs of this study

11. Would you like to share anything else with me?

Appendix X – Draft questionnaire

Process mapping the released offender health pathway

Questionnaire

Part 1: Demographic details

1. Name
2. Date
3. Age
4. Sex
5. How will you describe your ethnicity
6. Is this your first sentence
7. How long was the sentence you were given and when will it finish?

Length of sentence

End date of sentence.....

8. When were you released into the community
9. What are your license conditions
10. Highest level of education
 - a- Degree or equivalent
 - b- Higher education or equivalent (below degree)
 - c- GCE/GCSE A-levels or equivalent

- d- GCE/GCSE O-levels or equivalent
- e- Other qualifications at NVQ level 1 or below
- f- No formal qualifications

11. What is your employment status

- a- Paid/self- employed
- b- Unemployed
- c- Unemployed and looking for work
- d- Unable to work (long-term sickness/disability)
- e- Retired
- f- Looking after family or home
- g- In full-time education
- h- Doing something else

12. Are you on any form of benefits

13. Are you homeless

14. Do you have a health condition

15. Are you registered with a GP

16. What is your marital status

17. Have you got any kids (how many)

Part 2: Health profile

1. In general, would you say your health is (rand, 1):

Excellent

Very good

Good

Fair

Poor

How TRUE or FALSE is each of the following statements for you?

2. I seem to get sick a little easier than other people (rand, 33).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

3. I am as healthy as anybody I know (rand, 34).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

4. I expect my health to get worse (rand, 35).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

5. My health is excellent (rand, 36).

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

6. I have a health condition which affects my quality of life?

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

7. When I have a health need, I find it easy to see someone about my healthcare

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

8. I have difficulty accessing or registering with health services?

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

9. Access to nurses in the community in settings I visit for non-health needs has the potential to improve my uptake of health services

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

10. Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago

Somewhat better now than one year ago

About the same

Somewhat worse now than one year ago

Much worse now than one year ago

11. At present, if you need some health advice, where would you go?

Doctor/GP surgery

Walk in centre

Accident and Emergency

None of the above and hope the problem will go away

12. Would any of the following health promotion services be of use to you?

Drug/alcohol

Health eating/Health lifestyle

Sexual health awareness

Giving up smoking

Blood pressure/cholesterol checks

Any other? Please give details

12.If any of these were available, where would you like to access them?
(prompt: GP surgery, health centre, pharmacy, probation office, job centre,
place of worship)

Appendix XI – General health scale of the RAND 36-Item short form health survey 1.0

(Questions used to determine cases)

1. In general, would you say your health is:

Excellent

Very good

Good

Fair

Poor

How TRUE or FALSE is each of the following statements for you?

33. I seem to get sick a little easier than other people.

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

34. I am as healthy as anybody I know.

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

35. I expect my health to get worse.

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

36. My health is excellent.

Definitely true

Mostly true

Don't know

Mostly false

Definitely false

Appendix XII: Participants information sheet

Participant Information Sheet

Study title

Process Mapping the Released Offender Health Pathway

Invitation paragraph

You are being invited to take part in a Burdett Trust funded study aimed at mapping the released offender health pathway. The Burdett Trust for Nursing is an independent charitable Trust which was established in 2002 with the aim of making charitable grants to support nursing contribution to healthcare. The Trustees target their grants at projects that are nurse-led and that empower nurses to make significant improvements to the patient care environment.

Before you decide, it is important that you understand why this research is being carried out and what your participation involves. Please take time to read the following information carefully, and discuss it with your probation officer if you wish. If anything is unclear or you would like more information about this research, please do not hesitate to ask.

What is the purpose of the study?

The purpose of this study is to map the released offender health pathway in order to identify 'touch points' in the community where nurse led interventions can be delivered.

Why have I been chosen?

You have been selected for inclusion in this study due to your license condition which indicates that you will be in touch with the probation service for over six months.

Do I have to take part?

- Participation is entirely voluntary

- This study has no connection with your license condition and will not influence your probation officers appraisal of you
- If you decide to take part you will be asked to sign a consent form
- You are free to withdraw at any time and without giving a reason
- Being involved or not taking part will not affect your current license condition at all

What will happen to me if I take part?

- You will be asked to fill a questionnaire in the first instance. This questionnaire is designed to collate your health profile to date
- Following this, if you are selected as a case, you will then be interviewed once every 4 weeks
- This interview will be an in-person (face-to-face) interview which will be done in a quiet office at the Trust, and will take no longer than 1 hour
- The interview will be scheduled to be held on the same day you have been scheduled to visit your probation officer
- The interview will be tape recorded to ensure that I capture all that you say
- You will be asked to sign an Informed Consent Form prior to the interview being conducted

How is confidentiality maintained?

- Data will be protected by keeping questionnaires, transcripts and interview tape in a secure facility
- Audio recordings and transcripts will be stored in a secure and separate place from consent forms and personal information
- Any quotes used in the research will use pseudonym rather than your name.
- Once the data has been examined, these will be destroyed
- External hard drives and USB devices will be password protected
- After the interview, I will listen to the recording and type up what was said – the interview will then be deleted from the audio-recorder
- What you say to me in the interview is completely confidential. This means that whatever is spoken about in the interview will not be communicated to other people except where you tell me that you, or someone else, are at risk of harm or danger. If this is the case, I will inform your probation officer about this

What are the possible benefits of taking part?

- This study has no affiliation to the NHS or CJS and cannot offer any health, social or legal help
- However, the benefits of taking part in this study are that you will have the opportunity to share your experience of the barriers you have faced in accessing health services on release and what you think can be done to improve this
- In addition, your views on the most appropriate locations for the delivery of nurse led interventions to released offenders in the community will also be sought

What will happen to the result of this study?

- The result of this research will be presented in a written report as a doctoral thesis and a copy of this will be handed over to the probation Trust and the Burdett Trust for Nursing
- All hard data will be stored in a locked filing cabinet at the University of Wolverhampton and electronically under secure password for 2 years in line with the Data Protection Act

Who has reviewed the study?

This study has been approved in accordance with the principles and procedures of the University of Wolverhampton School of Health and Wellbeing Ethics Committee, the National Offender Management Service Research Committee on behalf of the Ministry of Justice and Staffordshire and West Midlands Probation Trust.

What if something goes wrong?

At the end of the interview, if you feel upset or need further help or advice, or if there is anything about the research process you are unsure about; please let the researcher know who will then advise you on who you could contact.

What do I have to do?

If you decide to participate, please complete and return the enclosed/attached consent form to your probation officer.

Contact for further information

For further information, or to enquire about any aspect of this project, please contact in the first instance:

Cyril Eshareturi

Centre for Health and Social Care Improvement

School of Health and Wellbeing

University of Wolverhampton

Telephone: 01902 518644

E-mail: Cyril.Eshareturi@wlv.ac.uk

Thank you for taking the time to read this information.

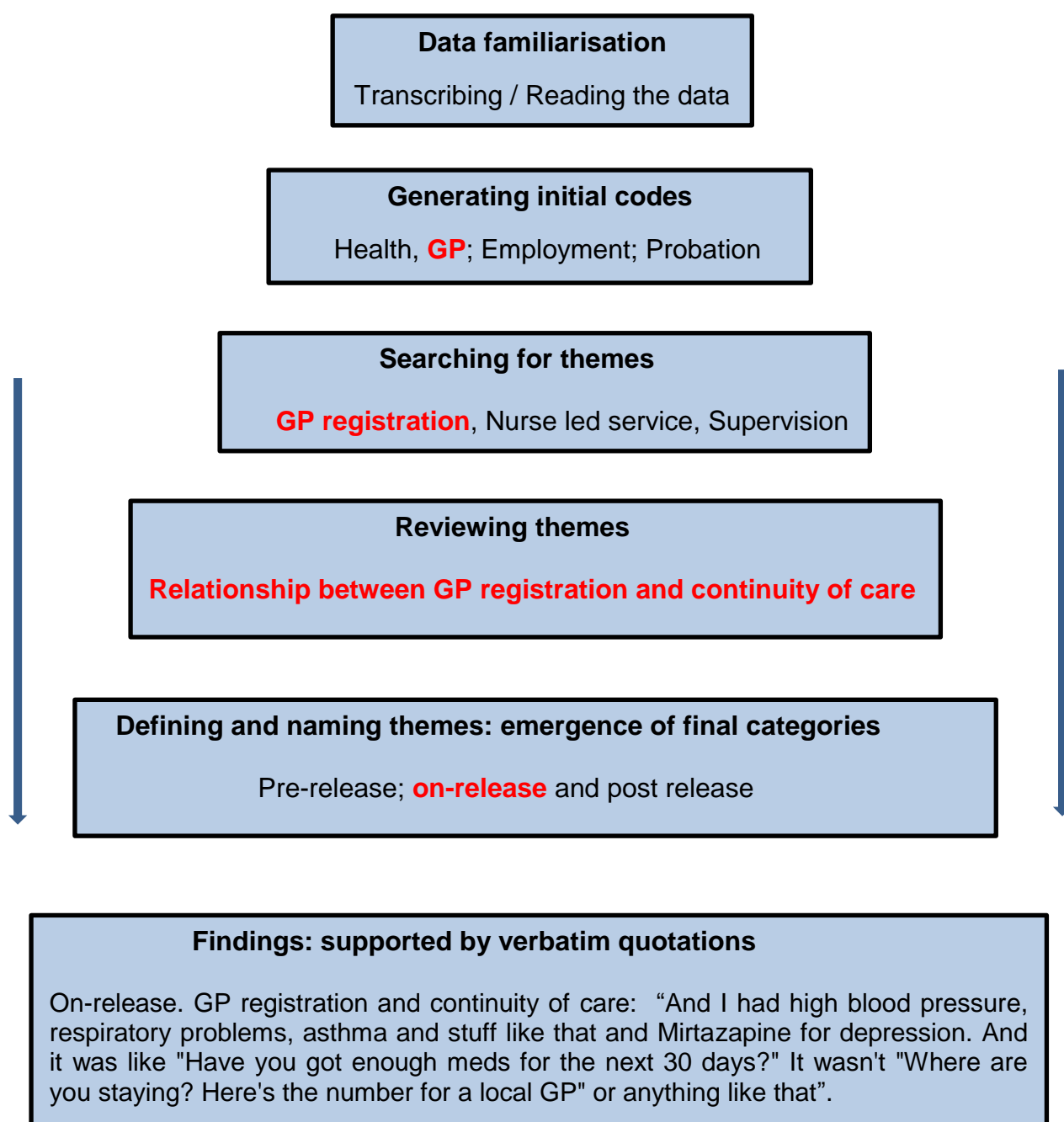
Appendix XIII – Risk analysis

The table below is a standard template for potential risks to this research, not presumed to be exhaustive, but was used as a guide to build upon.

Risk	Assessment	Countermeasures and contingencies
Verbal or physical aggression to researcher	Likelihood: Low to Medium (All contact will be made in the premises of the Probation Trust)	Countermeasure: Researcher to enrol for a level 3 course on the management of actual or potential aggression
	Impact: Medium	Contingency plan: Involvement of individuals who have had no prior history of verbal or physical aggression within the premises of the Probation Trust
Slippage in scheduling of interviews	Likelihood: Medium to High (Interviews rescheduled to be held at a later time)	Countermeasure: Interviews planned to be held on the same day participants are required to visit their probation officer
	Impact: Medium (Impinge on progress of the research)	Contingency plan: Begin analysis of interviews already conducted and concurrently work on other aspects of the project such as analysis of questionnaires.
Technical difficulties in terms of computer software and Hardware	Likelihood: Low (up-to-date high quality hardware and software available in the University of Wolverhampton)	Countermeasure: Input data as soon as received and make multiple backup copies of files.
	Impact: High (analyses must then be achieved using sources which may compromise the integrity of data)	Contingency plan: Analyse data from one of multiple copies.
Project management issues	Likelihood: Low (I have prior experience in project management)	Countermeasure: Ensure clarification of all objectives and the 'manner and way' each objective will be achieved prior to the commencement of the research.
	Impact: Low	Contingency plan: Supervisors for guidance.

Operational issues: My illness and/or absence for unforeseen circumstances	Likelihood: Low	Countermeasure: Forward planning, deadline checks and regular meetings with supervisors
	Impact: Low	Contingency plan: To be agreed with supervisors
Operational issues: difficulty in recruiting participants	Likelihood: Medium	Countermeasure: Stress the aims and objectives of the research in user-friendly terms and emphasise the positive outcomes for participants in terms of improving services which would directly affect their quality of life
	Impact: High	Contingency Plan: Use large sample
Interviewees not responsive	Likelihood: Medium	Countermeasure: Prompt reminders and good diary keeping
	Impact: High	Contingency Plan: Contact other interviewees.

Appendix XIV – Qualitative data analysis sample process



- 1- Data familiarisation: Transcribing the data, reading and re-reading the data and noting down initial ideas
- 2- Generating initial codes: Coding features of the data in a systematic fashion across the entire data set and collating data relevant to each code
- 3- Searching for themes: Collating codes into potential themes and gathering all data relevant to each potential theme
- 4- Reviewing themes: Re-checking themes and establishing a relationship between themes
- 5- Defining and naming themes: Refining the specifics of each theme and generating clear definitions towards clarifying the overall story of the analysis
- 6- Findings: Selection of vivid compelling extract examples which were used in the presentation of the findings

Appendix XV – Qualitative data analysis sample script

Silence dialogue at sixth month of follow up with BR

Key

Blue: Pre-release

Yellow: On-release

Red: Post release

Green: Nurse led service

CE- Cyril Eshareturi

BR- Silent voice

CE: So were you at work today as well?

BR: I've been to work and I've come straight here.

CE: Okay excellent. This is our sixth month so this interview is just basically a recap of some of the key themes that we've been able to generate so far.

BR: Yeah of course.

CE: And at the end of the interview I'm going to tell you how we'll progress moving forward. Although this is the sixth month, it doesn't mean it's the end. Obviously I wouldn't have to see you every month as we were seeing each other previously but then if you need to see me for anything you can always get in touch with me..

BR: Okay that's lovely yeah.

CE: But shall we just do this now?

BR: Okay.

CE: The first major question is how can we make healthcare accessible for people coming out of prisons?

BR: As I've stated before, everybody coming out of prison on licence have to come to the Probation Office, and perhaps they could have an office set up for a nurse so they can registered with a doctor. Because in prison the facility is not there. And some offenders might go to a different area so they've got no doctor, no nurse. So if there was a facility in the Probation Service they would then be able to locate the doctor, a nurse, a dentist, something like that.

CE: So such a facility would be with basic Probation led by the nurse?

BR: Yes.

CE: Okay I see your point.

BR: Or somebody on behalf of the doctors, you know like a medical secretary, somebody with experience.

CE: Some participants have suggested that a nursing appointment service at the Probation Service would be useful. So a nursing appointment service is basically a service where you have a nurse running it and then somebody can ring in to say "Can I come in at three o'clock to see this nurse?" So what are your thoughts on this?

BR: What do I think about it? Yes, appointment system, yes. For those, so I've come today to see the Duty Officer because I've just come out of prison, and if they've got to go somewhere else then to telephone in to that nurse would be a good idea to either come back later that day or the next day. Because they might have to report to the Police as soon as it's reported to Probation or to the solicitor.

CE: I see what you mean.

BR: Yeah so I think that would be a good idea as a drop-in or an appointment.

CE: Some participants have suggested a drop-in centre. The first is an appointment service now they've said a drop-in centre led by nurses. So the former question was one around an appointment service but some participants have said a drop-in centre would make more sense being led by a nurse again at the Probation Service. What are your thoughts on this? On the drop-in centre?

BR: Yeah I think all three would be a very good idea.

CE: So if I asked you what would you prefer, would you prefer a drop-in centre or a nursing appointment service?

BR: Based in Probation?

CE: An appointment service will be where you ring up to see "Can I have an appointment at two o'clock to come and see a nurse?" or a drop-in centre which would be...

BR: But if they have a drop-in centre then they've all got to wait in line haven't they?

CE: Yes.

BR: To see that particular nurse or nurses. That might get a little bit aggravating especially if they've just come out of prison and they've got to wait in a queue because it's like that in prison you see, they have to wait.

CE: I see.

BR: Queue up for the meds and they have to wait and so that could still affect them mentally.

CE: I see what you mean yeah.

BR: So I think if it's based here and they're just coming out of prison, come to see the Probation Officer, they're there straight away. Have you got a doctor? Have you got a local nurse? Have you got a local hospital? Have you got a dentist?

CE: So which would you prefer?

BR: I'd prefer the first one.

CE: The appointment service?

BR: Yeah.

CE: Okay excellent.

BR: Because the drop-in centre, in prison you line up wait for your meds and they haven't got that break away from it.

CE: Okay. Would an open evening for health issues led by a nurse be useful?

BR: Yes it would. Open evening yeah I think that within 14 days of them being released from prison I think that would work.

CE: So where would be an ideal location to have such an open evening?

BR: Near to the Probation Service because everybody knows where the Probation Service is, where they've got to go. So near to the Probation. Or if they do a late night Probation it could be linked to the late night.

CE: Alright excellent. Do you envisage any problems could arise as a consequence of disclosing health issues? So for instance, as a consequence of disclosing issues to this nurse do you envisage any problem with your Probation Officer?

BR: No. because if there's any issues in prison the Probation Officer would know. But I think for the nurse, there's something about the Data

Protection Act as well isn't there? But I think the Probation Service should know that their offender has got A,B or C wrong with them and I think the nurse should tell the Probation Officer.

CE: So how do you propose for this to work with regards to confidentiality?

BR: Via this system, just make notes whereby the Probation Service can see. Just Probation Officers can see what medication that person is on, what issues that person has had. Because somewhere down the line if that person is on Probation or licence for a year or two years, the Probation Officer needs to be aware of what medication they're on. Personally. Because if they've just come out of prison and they're still on that drug what brings them off?

CE: Is it methadone?

BR: Yeah methadone. I think the Probation Officer should be aware that they're still on that methadone. Because if they're back in front of the Police or the judge then the Probation Officer should know that they're on 20mg coming down to 15mg going up to 30mg. And I think the Probation Service can do a report then ready for the court to say 'That person was on so many mgs, reduced it and then all of the sudden went up so yes there's a problem there.'

CE: So what if somebody was seeing the nurse because they assumed that they were having a conversation with the nurse that was private. So you have a nursing appointment service, and then you went in to see the nurse because you felt, 'I can have a conversation with this nurse that's private, around my health, not my criminal behaviour.' So somebody goes and discloses to the nurse that he's HIV positive, how do you propose that that works because the person is saying "Look I'm HIV positive, I'm not on antiretroviral drugs, how can you help me to get my drugs back? I need to get back on my ARVs."

BR: There again I think they should disclose.

CE: So you think such a service should not be confidential in that sense?

BR: Not where offenders are concerned, no.

CE: Okay excellent. So your suggestion will be?

BR: The person who is on license, the NHS have a duty of care to let their Probation Officer know about their mental and physical health. I think that would work. If nurses don't tell their Probation Officer and that person with HIV started to pick up prostitutes in the area and then they're picked up for kerb crawling and then they're before the court, I think the Probation Officer ought to know something like that. Because at the end of the day they have to give a report to the courts about that particular person if they're still on licence for recall.

- CE: Some people have said that managing entry into the community was a big problem for them. Re-entry in the sense of leaving prison into the community. How was it for you?
- BR: I had a very good Probation Officer when I came out. I could talk to her about anything and I had to do everything myself, the prison did nothing for me, I had to find my own accommodation and XXX was a good help there. Re-entry? Benefits, there was a problem with my benefits but I got support from my partner who helped me. But if I had nobody to help me, I think there would be a major problem. That's why I've now got into this job, support work, so I can give people the support that a lot of people don't get and what I never had.
- CE: Okay. So on leaving prison, what exactly did prison staff do for you? Did they do anything?
- BR: The prison?
- CE: Yeah.
- BR: They just gave me day release in the last month in the sentence. But I think they help with me finding accommodation, otherwise I would have come out to no accommodation. And if I didn't find accommodation then I wouldn't have been released on Christmas eve, where would I have gone?
- CE: Okay. And you got in touch with your Probation Officer when you were on day release?
- BR: Yes. I let them know when I was due on the day release and that I was going to see the property. And then a personal letter to my Probation Officer was handed in to reception so XXX could know on the Monday that I'd been to see the property on the Saturday and that I wanted to take that property. So I had to do it all myself but the probation she was marvellous with me, just followed everything. Everything fell into place for me. I know you've got inside Probation in prison, they're a waste of time. I think Probation on the outside should interact more with their person inside a couple of months before they're due out, they should get that report together. Like I did with XXX, I was on the phone to her, sent her letters. And she replied and responded back and I think most Probation Officers should do that ready for reintegration.
- CE: So the Probation Officer should get in touch with the individual in prison not the Probation Officer in prison?
- BR: Yeah well the Probation Officer in prison did nothing for me. He was suspended in my last two months of my prison sentence he was

suspended. I had no Probation Officer then in the prison, Offender Manager I should say. Offender management.

CE: Right so hypothetically the ideal situation is supposed to be that prior to release a Probation Officer outside gets in touch with your Offender Manager inside to liaise with re-entry procedures for the individual is that right?

BR: Yeah or with the offender themselves. Because I made contact with XXX and she helped me all the way, right in the last month with my accommodation and everything because I came out in HDC and she was my support.

CE: Oh right excellent. With regards to health a major theme was there was lack of pre-release support with regards to health. Was there any support to prepare you for release?

BR: No. I couldn't get any medication or a prescription for medication, they'd tell me to go and see a doctor. And I had to get in touch with my old doctor from the area that I was living in before I came out because I went to a different area. And they read through my notes and I was asthmatic and they gave me some inhalers. But if I didn't have my old doctor I would have had to go to the hospital? I don't know what I would have done?

CE: But before leaving prison do you get asked if you even have a GP? Do you get asked that question?

BR: No I was never asked that. And then I told them "I haven't got a GP to come out to in the area that I was moving to and could I have a prescription for medication?" and they said "No".

CE: And there was nothing in place to facilitate that?

BR: No. Not in the prisons no. Not for me. A lot of people came out without medication and they were told just to go to find a doctor or go to the hospital if need be.

CE: So when they tell you prior to release when they said "Find a doctor" did they give people the tools to access?

BR: No.

CE: Just 'Find a doctor'?

BR: Find a doctor, find a nurse or going to the walk-in centre. Going into a walk-in centre that's not really good because they could give you (unclear 16:25) but then like me I'm on a respiratory tablet as well, they might not have given me a respiratory tablet because they don't know my background. I could have asked for all sorts of stuff or a

person can but they don't know the background so it's important for them to have a doctor for the nurse to see, that's why I think something at Probation where they can have access to the records from the prison.

CE: It would be helpful. Okay excellent.

BR: I think with the prison, with Probation and with healthcare they all interlink and I think that's what's needed.

CE: Excellent. Almost everybody said family support was crucial in helping them reintegrate because you've just mentioned there was very little support to prepare you with regards to health and even accessing structural things. Almost everybody seemed to touch on the fact that family was crucial in helping them access jobs, benefits, accommodation. How was this for you?

BR: I did access my own benefits. It took a while. My daughters they couldn't really help me because they've got their own places, they couldn't have me there. And I don't think their husbands wanted me there. So there is no way they could help me with accommodation, with money, nothing.

CE: And your partner you mentioned?

BR: Yeah when I was in prison my partner of 21 years got in touch with my daughter to tell her to tell me that he's moved on and I was absolutely devastated. But then somebody I'd known for 28 years had seen XXX out with his new wife and then he got in touch with me because he was on his own and he came to see me and so we just built up a relationship while I was in prison and since I've come out. And he made a load of enquires about accommodation for me.

CE: So that was quite helpful as well?

BR: Yeah it was quite helpful. Now 15 months on my partner says he wished now I would have gone to live with him straight away. But we didn't really know each other and it wasn't that kind of relationship. But he says now he regrets it, me having to go into that property when I could have gone there. But I needed to go into that property so we could get to know each other, otherwise I could have been out on my ear three months later.

CE: Exactly. Well excellent. So we've talked about all of the major things which were things like where to provide the nursing service. The lack of support in prison. The kind of help that people would like to see from the Probation Officers as well. But are there any things that you think would be good to include in the research that I omitted or missed?

BR: I think the Probation Officer should meet the offender personally prior to their release. So if you were my Probation Officer, to come to see me to introduce yourself I think that would help because you've got a face and you've got somebody that you can relate to. Even though I didn't meet Marjorie, I was on the phone to her. But I think for a Probation Officer to go in and meet their offender, I think that would be good. Because the offender then will think, 'I've got a Probation Officer, I can go out and see, I'd know their face' and then they could start to build on that.

CE: Okay. I think that would be a good idea but have you given thought to the workload that this might entail?

BR: Yes, well you know that will work around it. Because the workload will be more when that offender comes out.

CE: So what questions would you like me to ask the Probation Officers? What would you like answers to that perhaps ordinarily you're not getting answers to or you think they should be doing more towards that?

BR: No I've got no questions for them because I've been really lucky.

CE: So a suggestion for them?

BR: Yeah. Or via video link. You know if there was a video link, well I know there is at some courts but if the video link was put in Probation Services then they could meet their client/offender.

CE: So as it stands now, prior to release you don't get in touch with the Probation Officer until release is that correct?

BR: Just before-- oh yes, day of release you then meet your Probation Officer.

CE: Day of release, that's when you meet the Probation Officer?

BR: Yeah.

CE: But before then you liaise with the Offender Manager in the prison?

BR: Yeah.

CE: And then the day of release...

BR: And then the Offender Manager should liaise with outside of Probation but mine never did. That's why I phoned XXX to say "What's happening here, is this something you can fill out with me?" So I think Offender Managers, I don't think they're qualified Probation Officers. I

don't think they're qualified. So no I think personally to me if they've got time, if not video link.

CE: Video link okay. Is there anything else you want to tell me? Anything else at all you want to share with me?

BR: No.

CE: Anything else you think I should know or include in the research?

BR: No I think you've gone over everything.

CE: So this ends the interview, I'll just turn this off.

Appendix XVI – Profile of interview participants – silent voices

Name	Age	Ethnicity	Gender	Sentence	Offense	Disability	Employment
CC	44	Mixed: white and black Caribbean	Male	CJA – Std Determinate Custody	Class B – Cannabis – Production or being Concerned in Production of	No Disability	Employed
BR	59	White: British	Female	CJA – Std Determinate Custody	Dishonestly make a false representation to make a gain for self/other or to cause loss/expose another to a risk	No Disability	Unemployed
AR	28	White: British	Male	CJA – Std Determinate Custody	Burglary	No Disability	Unemployed
SP	27	White: British	Male	CJA – Std Determinate Custody	Robbery	No Disability	Unemployed
LM	80	Black or Black British: Caribbean	Male	Adult Custody 12m plus	Sexual activity (male and female) - including with a child under 16	No Disability	Retired
SK	45	Asian or Asian British: Pakistani	Male	CJA – Std Determinate Custody	Other Class A Drugs - Having possession of	Reduced Physical Capacity	Employed
DH	52	White: British	Male	CJA – Std Determinate Custody	Sexual activity with a female child under 16	No Disability	Unemployed
NH	49	White: British	Male	CJA – Std Determinate Custody	Class B - Amphetamine - Supplying or offering to supply	No Disability	Employed

